

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND  
Items 3,6 Film 0195 1-19-56 et  
4176  
CERTIFICATE OF DEATH

04144

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Chatham</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>8 mo's</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MIH - NINDB</u>				d. STREET ADDRESS <u>ite #</u>			
3. NAME OF DECEASED (Type or print) First <u>Ashley</u> Middle <u>Omer</u> Last <u>Allen</u>				4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>WHITE W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12 April 1903</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>UNKNOWN</u> Alonza Allen				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> Sally Fathera			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Chart. Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Respiratory</u> <u>193X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Glioma Brain Stem.</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August, 1955</u> to <u>7 April, 1956</u> , that I last saw the deceased alive on <u>7 April, 1956</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>720 Center Drive Bethesda</u>				DATE SIGNED <u>8 April 56</u>			
ACTUAL SIGNATURE <u>E. J. Laskowski</u> M.D.				PHYSICIAN'S NAME (Type) <u>E. J. Laskowski</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/11/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Allen Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pittsylvania Co., Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Mary.</u>				24a. REC'D BY REGISTRAR <u>Bessie M. Thompson</u> DATE <u>4/10/56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

APR 12 1956

RECEIVED

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE

## CERTIFICATE OF DEATH

04145

Reg. Dist. No. 214

4177

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING,</b>	
c. LENGTH OF STAY IN 1b <b>35 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>742 THAYER AVENUE</b>		d. STREET ADDRESS <b>742 THAYER AVENUE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LAWRENCE</b> Middle <b>HOWE</b> Last <b>ALLEN</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>27</b> Year <b>19 56</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/4/87</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CIVIL ENGINEER - retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV'T.</b>	
11. BIRTHPLACE (State or foreign country) <b>HARTFORD, CONN.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>REDFIELD HOWE ALLEN</b>		14. MOTHER'S MAIDEN NAME <b>ABBE LOUISE KING</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. ETHEL ALLEN, 742 THAYER AVE.</b>		Address <b>SILVER SPRING, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>160X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of left frontal sinus</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio Sclerotic Heart Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 5</b> , 19 <b>55</b> , to <b>April 27</b> 19 <b>56</b> that I last saw the deceased alive on <b>April 27</b> , 19 <b>56</b> , and that death occurred at <b>12:45</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. Marion Bankhead</b>		ADDRESS (Street, city or town, state) <b>9241 Col. Blvd. Silver Spring, Md.</b>	
PHYSICIAN'S NAME (Type) <b>J. Marion Bankhead</b>		DATE SIGNED <b>4/27/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/30/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GEO. WASH. MEM. CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner C. Humphrey</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>4/30/56</b>		24b. REGISTRAR'S SIGNATURE <b>Francis [Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ANALYSIS AND STATE OF - TREATMENT OF HEALTH - BALTIMORE, MD

1956 4 1874

RECEIVED  
MAY 7 1956



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4178

CERTIFICATE OF DEATH

041464

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BURTONSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>(SUPPLEMENT) PEOPLE'S DRUG STORE</b>		d. STREET ADDRESS <b>OURSLEER ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>SMITH</b> Middle <b>W.</b> Last <b>ALLNUTT</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>13</b> Year <b>1956</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 18, 1886.</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REAL ESTATE OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GEN. REAL ESTATE</b>	
11. BIRTHPLACE (State or foreign country) <b>DAWSONVILLE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWIN R. ALLNUTT</b>		14. MOTHER'S MAIDEN NAME <b>ANNA CHISWELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. MARGARET W. ALLNUTT, BURTONSVILLE, MD.</b>		Address <b>OURSLEER ROAD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: <b>420.1 Coronary Occlusion</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>?</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1955</b> to <b>13 April 1956</b> , that I last saw the deceased alive on <b>13 April 1956</b> , and that death occurred at <b>12:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>BURTONSVILLE, MD.</b> DATE SIGNED <b>4/13/56</b>			
ACTUAL SIGNATURE <b>William D. Aud</b> M.D.		PHYSICIAN'S NAME (Type) <b>William D. Aud</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>APR 16, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>UNION CEMETERY</b>	22d. LOCATION (City, town, or county) <b>BURTONSVILLE, CO., MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Baller</b>		24a. REC'D BY REGISTRAR <b>Francis J. Baller</b>	24b. REGISTRAR'S SIGNATURE <b>Francis J. Baller</b>

MEDICAL CERTIFICATION

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BUREAU V. S.

APR 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4179

## CERTIFICATE OF DEATH

04147

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Broke Grove Chronic Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dollie</u> Middle <u>F</u> Last <u>Altamus</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 20, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
13. FATHER'S NAME <u>Edgar E. Rankin</u>		14. MOTHER'S MAIDEN NAME <u>Dora J. Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address <u>Patient</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gen. PERITONITIS</u> DUE TO <u>PERFORATED ABDOMINAL VISCERA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>FAR ADVANCED CA-STOMACH</u> DUE TO (c) <u>5 YRS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 HRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 1, 1954</u> to <u>APR. 16, 1956</u> that I last saw the deceased alive on <u>APR. 15, 1956</u> , and that death occurred at <u>6:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Berley Ziegler</u> M.D.		DATE SIGNED <u>16 Apr 56</u>	
PHYSICIAN'S NAME (Type) <u>DR. T. B. Ziegler</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/20/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. W. Niles Co.</u> ADDRESS <u>2001 14th St. N.W. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE 4-18-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bertrude B. Lawler</u>

CERTIFICATE OF DEATH

1956

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document.]*

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document.]*

BUREAU V. S.

APR 23 1956

RECEIVED

## 4180 CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>822 Richmond Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Draper Wilson Armstrong</u>		4. DATE OF DEATH Month Day Year <u>April 5 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1890</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home modernizing</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLEY A. <del>WILLEY</del> Armstrong</u>		14. MOTHER'S MAIDEN NAME <u>KATE E. Snyder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>104-05-0929</u>	
17. INFORMANT Address <u>Wife - Mrs. Gladys Armstrong</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> 10915 DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-1</u> , 19 <u>56</u> , to <u>4-5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-5</u> , 19 <u>56</u> , and that death occurred at <u>10:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Sharpe</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>10644 Conn. Ave. Kensington, Md. 4-5-56</u>	
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/7/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>4/7/56</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

120

BUREAU V. S.

APR 9 1956

RECEIVED

04149

4181

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		MARYLAND		STATE D.C.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN KENSINGTON				TOWN WASHINGTON		422	
HOSPITAL OR INSTITUTION OR STREET ADDRESS KENSINGTON GARDENS REST HOME				STREET ADDRESS (If rural give location) 3133 CONNECTICUT AVE.			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) LUCY M. F. ASHTON				4. DATE OF DEATH (Month) (Day) (Year) APRIL 30 19 56			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 6/16/69	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) FRANKLIN CITY MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARTIN PERKINS				14. MOTHER'S MAIDEN NAME SUSAN BELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS MRS. ESTHER A. WILSON 3133 CONN. AVE., N.W., WASHINGTON, D.C.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				2 wks			
4510 IMMEDIATE CAUSE (A) Congestive heart failure							
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral art. Sclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Generalized art. Sclerosis							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from MAY 51, 19 51, to 30 APR., 19 56, that I last saw the deceased alive on 26 APR., 19 56, and that death occurred at M., from the causes and on the date stated above.							
SIGNATURE Charles W. Thompson M.D. 1714 - N - 2nd Wash. D.C. / May 56				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) TRANS. & BURIAL		DATE THEREOF 5/1/56		NAME OF CEMETERY OR CREMATORY WILDWOOD CEMETERY		LOCATION (City, town, or county) (State) BARTOW, POLK COUNTY, FLORIDA	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Frances Vatter		25. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
DATE 5/2/56							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

21AN

1911  
1133

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4182

## CERTIFICATE OF DEATH

04150  
Reg. Dist. No. 276

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Potomac</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Potomac</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. F. D. #2</b>		d. STREET ADDRESS <b>R. F. D. #2</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Catherine</b> Last <b>ATWOOD</b>		4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1869</b>
9. AGE (In years last birthday) yrs. <b>87</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Days <b>5</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Potomac, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Stearn</b>		14. MOTHER'S MAIDEN NAME <b>Cynthia Fawsett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Hazel A. Mannar-Same Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>cardio-respiratory failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cachexia - gen. arteriosclerosis</b> (c) <b>2 ann. fibrillation + multiple venous thromboses</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 2, 1953</b> , to <b>4/20/1956</b> , that I last saw the deceased alive on <b>4/20/56</b> , and that death occurred at <b>8:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rockville, Md.</b> DATE SIGNED <b>4/20/56</b> ACTUAL SIGNATURE <b>Stephen D. Jones</b> M.D. PHYSICIAN'S NAME (Type) <b></b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/23/1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>4/21/56</b>	24b. REGISTRAR'S SIGNATURE <b>Bessie M. Humphreys</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

RECEIVED V. S.

PR. 100 100

RECEIVED



## MEDICAL CERTIFICATION

VS. A15ME(5)  
SM 9/55

U.S. AIR FORCE

APR 17 1956

JOHN W. F.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4153 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04152

Reg. Dist. No. 223

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, RT. 1</u> d. STREET ADDRESS <u>Norwood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>James Lester Bender</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>4-3-1956</u> Month Day Year											
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7-6-88</u>		<b>9. AGE</b> (In years last birthday) <u>67</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Night watch man</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Charles Bender</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie Delauney</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>578-10-5886</u>				<b>17. INFORMANT</b> <u>Claude Bender, 3505 Ames St NE DC.</u> Address							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>															
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , <b>Accident</b> <input type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined cause</b> <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschart</u>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>									
<b>22a. BURIAL, CREMATION, REBURNAL (Specify)</b> <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>4/7/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>MOUNTAIN VIEW CEMETERY</u>				<b>22d. LOCATION (City, town, or county)</b> <u>SHARPSBURG, MARYLAND</u> <b>(State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Humphrey</u> <b>ADDRESS</b> <u>SILVER SPRING, MD.</u>						<b>24a. REC'D BY REGISTRAR</b> <u>4/6/56</u> <b>DATE</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>John R. Dadd</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U. S. DEPARTMENT OF AGRICULTURE



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4154 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04153

Reg. Dist. No. 223

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>207 Hudson Avenue</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>207 Hudson Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Ella</u> Middle <u>S.</u> Last <u>BERGMAN</u>				<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>3</u> Year <u>19 56</u>																	
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 20, 1882</u>		<b>9. AGE</b> (In years last birthday) <u>73</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>10</u></td> <td><u>13</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<u>10</u>	<u>13</u>		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<u>10</u>	<u>13</u>																				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> - - - - -		<b>11. BIRTHPLACE</b> (State or foreign country) <u>West Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>													
<b>13. FATHER'S NAME</b> <u>Joseph L. Stewart</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Fannie Forney</u>																	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>Yes-unknown</u>		<b>17. INFORMANT</b> <u>E. Wilson Stewart-1713 Highland Dr. Sil. Sp. Md.</u>																	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>found dead in bed</u>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																	
<b>20c. TIME OF INJURY</b> Hour _____ o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> _____ (County) _____ (State) _____															
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																					
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> <b>EXAMINER'S NAME (Type)</b> <u>Frank J. Broschart, M.D.</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>																	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>4/5/1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Rock Creek</u>		<b>22d. LOCATION</b> (City, town, or county) _____ (State) _____ <u>Washington D. C.</u>													
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>				<b>ADDRESS</b> <u>Bethesda, Maryland</u>		<b>24a. REC'D BY REGISTRAR</b> <u>4/4/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>E. Wilson</u>													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, marking the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



EDWARDS & B

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4184 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04154

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>1 yr</u>		d. STREET ADDRESS <u>3500 Powhatan Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>810 Bayfield St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Berke</u> Last		4. DATE OF DEATH Month <u>Apr</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>? - ? 1887</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>Friedman</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Dr Joseph Berke</u>		Address <u>same</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-25-56</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-27-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>	
22d. LOCATION (City, town, or county) <u>Balto</u>		(State) <u>md</u>		24a. REC'D BY REGISTRAR <u>APR 27 1956</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		ADDRESS <u>2100 Cutaw Place</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Patten</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, pending the ward, in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 27 1956

BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4185  
CERTIFICATE OF DEATH

04155

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7107 Conn. Ave. N.W.</u>		d. STREET ADDRESS <u>7107 Conn. Ave. N.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>STRONG</u> Last <u>BETHEL</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 11, 1883</u>
9. AGE (In years last birthday) yrs. <u>72</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Portland, Oregon</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Nelson Strong</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Stone</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Frances B. Rowan</u>		Address <u>30 Quincy St. Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> <u>434.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart Disease</u> DUE TO (c) <u>Lung pathology "Middle lobe syndrome"</u> 5 years 1 year		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>53</u> , to <u>April 22, 1956</u> , that I last saw the deceased alive on <u>April 22, 1956</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. J. Tamagna</u> M.D.		ADDRESS (Street, city or town, state) <u>7101 Conn. Ave. Che</u> DATE SIGNED <u>4-22-56</u>	
PHYSICIAN'S NAME (Type) <u>Irene G. TAMAGNA M.D.</u>		<u>Chevy Chase 15, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Point Mil. Academy</u>		22d. LOCATION (City, town, or county) (State) <u>West Point, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hader, Sons</u>		ADDRESS <u>1756 Pa. Ave. NW. Wash. DC</u>	
24a. REC'D BY REGISTRAR <u>4/24/56</u>		24b. REGISTRAR'S SIGNATURE <u>Frances B. Rowan</u>	

BUREAU V. 2

APR 26 1956

RECEIVED



4186

## CERTIFICATE OF DEATH

Reg. Dist. No.

04156

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>10 minutes</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NMMC, Bethesda, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lee</b> Middle <b>"J"</b> Last <b>BLOOM</b>				4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>17 March 1955</b>	
9. AGE (In years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b></b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>California</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>							
13. FATHER'S NAME <b>Allyn Arthur BLOOM</b>				14. MOTHER'S MAIDEN NAME <b>Jean KENNEDY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Father, Allyn Arthur BLOOM, 77 Chinlee, Lex. Park</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration &amp; Electrolyte</b> DUE TO <b>576</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>12 hrs</b> (c) <b>3 days</b> <b>Gastro-enteritis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Pneumonia</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>19 April</b> , 19 <b>56</b> , to <b>19 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>19 April</b> , 19 <b>56</b> , and that death occurred at <b>2:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>4-20-56</b>							
ACTUAL SIGNATURE <b>J. W. Stohlman, M.D.</b>				PHYSICIAN'S NAME (Type) <b>J. W. STOHLMAN, III, LT, MC, USN</b> <b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-23-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>				ADDRESS <b>7557 Wise Ave., Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 4-20-56</b>	
24b. REGISTRAR'S SIGNATURE <b>W. C. Passelty</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM V. S.

APR 23, 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4187 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0415724  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>26 YRS.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>410 SILVER SPRING AVENUE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DEWITT</b> Middle <b>H.</b> Last <b>BODINE</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>11</b> Year <b>19 56</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/22/90</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner of ice business</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>AMERICAN ICE CO. in Silver Spring,</b>			
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>WILLIAM F. BODINE</b>				14. MOTHER'S MAIDEN NAME <b>EDNA BRYANT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE</b>		17. INFORMANT <b>MRS. EVA C. BODINE, 410 SILVER SPRING AVE. SILVER SPRING, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage + laceration</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>bullet wound in rt. temple</b> DUE TO (c) <b>Sudden</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self-inflicted .22 cal bullet wound rt temple</b>			
20c. TIME OF INJURY Hour <b>9:30</b> a. m. <b>4/11 1956</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Silver Spring Monty Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/13/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BRADLEY CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MANASSAS, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey, SILVER SPRING, MD.</b>				24a. REC'D BY REGISTRAR DATE <b>4/13/56</b>		24b. REGISTRAR'S SIGNATURE <b>Francis P. [Signature]</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 16 1936

RECEIVED  
APR 16 1936

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04158  
4188 CERTIFICATE OF DEATH

Reg. Dist. No. 214...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kensington</u>	LENGTH OF STAY (in this place) <u>6 weeks</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glenmont</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kensington Gardens San.</u>		STREET ADDRESS (If rural give location) <u>Lutes Lane</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>BERTHA</u> <u>A.</u> <u>BREADY</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 18</u> <u>1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>June 5, 1882</u>
9. AGE last birthday <u>73</u> yrs.		10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>August Priebe</u>		14. MOTHER'S MAIDEN NAME: <u>Augusta ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-24-4697</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Maurice W. Robey, Lutes Lane</u>		<u>Glenmont, Maryland</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
4-7 IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>		<u>3 months</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerosis; Heart Disease</u>		<u>yr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertension</u>		<u>yr</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>July 15, 1955</u> , to <u>April 18, 1956</u> , that I last saw the deceased alive on <u>April 17, 1956</u> , and that death occurred at <u>8:25 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>4/18/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/20/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Rockville Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-20-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 24 1956

BUREAU V. S.

4189

## CERTIFICATE OF DEATH

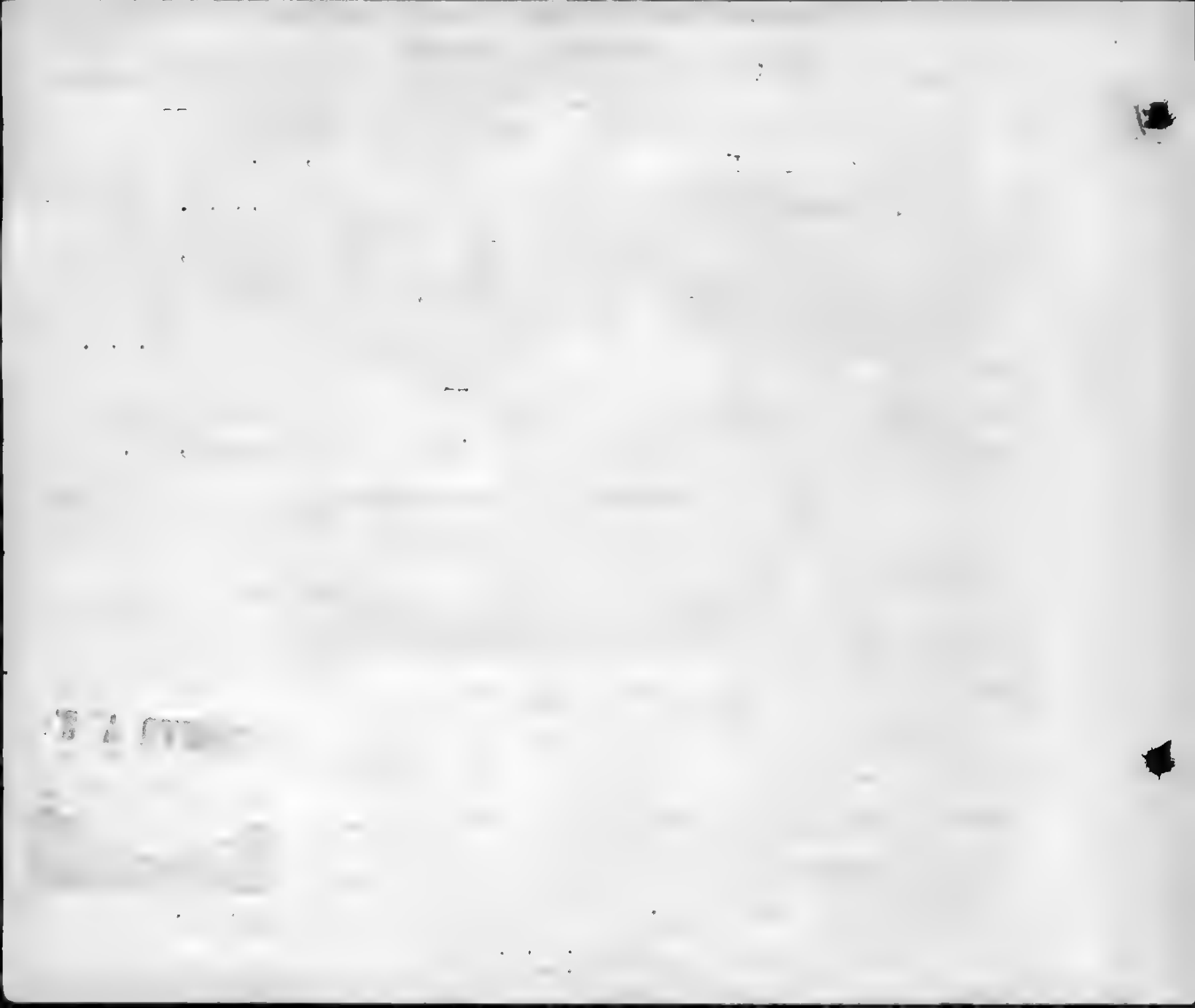
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>--</b> b. COUNTY <b>--</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norbeck</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Philomenas Home</b>		d. STREET ADDRESS <b>2331 Cathedral Ave., N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>Deneen</b> Last <b>Bridwell</b>		4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>1956</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 16, 1872</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Sparta, Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Deneen</b>		14. MOTHER'S MAIDEN NAME <b>--</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Ansel G. Arapian</b>		3913 Halsey Street <b>Kensington, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8-1</b> , 19 <b>55</b> , to <b>4-2</b> , 19 <b>56</b> that I last saw the deceased alive on <b>4-1</b> , 19 <b>56</b> , and that death occurred at <b>2:35</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Harry J. Kicherer</b> M.D.		Silver Spring, Md. <b>4-2-56</b>	
PHYSICIAN'S NAME (Type) <b>Harry J. Kicherer, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/4/1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Niles Co.</b>		24a. REC'D BY REGISTRAR DATE <b>4-2-56</b>	
24b. REGISTRAR'S SIGNATURE <b>James P. Patton</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4171

## CERTIFICATE OF DEATH

04160

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>202 MONROE ST.</u>				d. STREET ADDRESS <u>202 MONROE ST</u>			
3. NAME OF DECEASED (Type or print) First <u>Edwin</u> Middle <u>WARFIELD</u> Last <u>Broome</u>				4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 26, 1885</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>9</u> Hours <u>-</u> Min. <u>-</u>		IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EDUCATOR - RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Supt. Mtg. Co. Schools</u>		11. BIRTHPLACE (State or foreign country) <u>DARNESTOWN, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>ALEXANDER BROOME</u>				14. MOTHER'S MAIDEN NAME <u>MARY WARFIELD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HANNAH M. BROOME</u>	
				Address <u>202 MONROE ST. ROCKVILLE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO <u>Chronic Myocarditis</u> (c) <u>Chronic Myocarditis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>2/1/1952</u> to <u>4/5/1956</u> that I last saw the deceased alive on <u>4/2/1956</u> , and that death occurred at <u>0811</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring</u> DATE SIGNED <u>4/6/56</u>							
ACTUAL SIGNATURE <u>J.W. Bird</u>				PHYSICIAN'S NAME (Type) <u>J.W. Bird</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 9, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DARNESTOWN PRESBY. CH. CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY CO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4/6/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Laurel Krogtal</u>		Per. <u>F. Long</u> S. <u>M. Long</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04161

4190

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5521 Johnson Avenue</b>		d. STREET ADDRESS <b>5521 Johnson Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELIZABETH</b> Last <b>BROWN</b>		4. DATE OF DEATH April 30, 19 56	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1867</b>
9. AGE (In years last birthday) <b>88</b> yrs		IF UNDER 1 YEAR: Months <b>9</b> Days <b>2</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Tavenner</b>		14. MOTHER'S MAIDEN NAME <b>Fanny Landis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b> (If yes, give war or dates of service) <b></b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Fannie M. B. Melton-Item# 2</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>471X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac Decompensation &amp; auricular Fibrillation</b> DUE TO <b></b> (c) <b>Bronchial Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hr.</b> <b>3 weeks.</b> <b>3 weeks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pernicious Anemia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1949</b> , 19____, to <b>date</b> , 19____, that I last saw the deceased alive on <b>29 April</b> , 19 <b>56</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John G. Ball</b>		ADDRESS (Street, city or town, state) <b>7936 Georgetown Rd. Bethesda Md</b>	
PHYSICIAN'S NAME (Type) <b>John G. Ball</b>		DATE SIGNED <b>4/30/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>		22b. DATE THEREOF <b>4-30-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hiland Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Des Moines, Iowa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		ADDRESS <b></b>	
24a. REC'D BY REGISTRAR <b>DATE 4/30/56</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4191

CERTIFICATE OF DEATH

04162

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Maryland</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>5105 Livingston Road, S. E.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>John</b> Last <b>Bruckschen</b>		4. DATE OF DEATH Month <b>April</b> Day <b>22</b> , Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 19, 1889</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Truck driver</b>	
11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>G. Bruckschen</b>		14. MOTHER'S MAIDEN NAME <b>Annie Porter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>bilateral hydronephrosis &amp; pyelonephritis, uremia</b> 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>carcinoma of the urinary bladder</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 16, 1956</b> , to <b>April 22, 1956</b> , that I last saw the deceased alive on <b>April 22, 1956</b> , and that death occurred at <b>4:35 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Mehran Goulian</b> PHYSICIAN'S NAME (Type) <b>Mehran Goulian</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/26/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Hall</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co.</b>		24a. REC'D BY REGISTRAR <b>4-24-56</b>	
ADDRESS <b>517 11th St. S.E.</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

BUREAU V. A.

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## MEDICAL CERTIFICATION

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BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4193

CERTIFICATE OF DEATH

Reg. Dist. No. 04161

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>1 mo. 7 days</b>		d. STREET ADDRESS <b>3000 Connecticut Ave., N.W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Willits</b> Last <b>BURTON</b>		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 16, 1877</b>
9. AGE (In years last birthday) <b>78</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Albert B. Willits</b>		14. MOTHER'S MAIDEN NAME <b>Anna White</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>(Son) Norman T. BURTON, 3000 Conn. Ave., Wash. D.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO " " <b>metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma, breast</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Indefinite</b> <b>5 years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3 March</b> , 19 <b>56</b> , to <b>10 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10 April</b> , 19 <b>56</b> , and that death occurred at <b>9:05 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Frederick W. Meyer, Jr., M.D. U.S. Naval Hospital, Bethesda, Md. 4-11-56</b>			
ACTUAL SIGNATURE <b>Frederick W. Meyer, Jr.</b>			
PHYSICIAN'S NAME (Type) <b>Frederick W. Meyer, Jr. CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-13-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>4-11-56</b>	
24b. REGISTRAR'S SIGNATURE <b>May E. Ganssely</b>			

37. 1718016

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4194

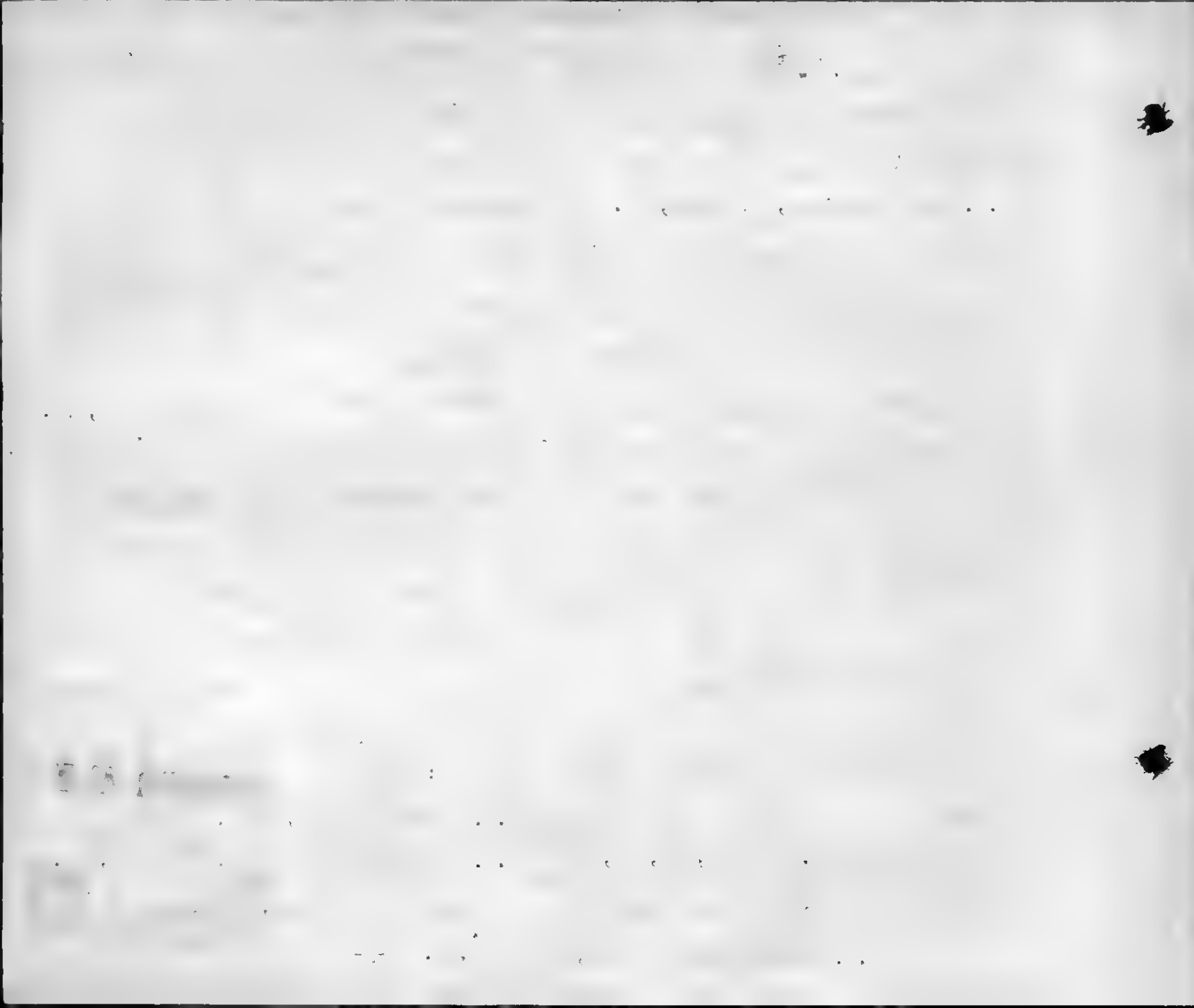
## CERTIFICATE OF DEATH

04165  
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>	
d. STREET ADDRESS <b>609 Cameron Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Ferris</b> Last <b>CAGLE</b>		4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 November 1955</b>
9. AGE (In years lost birthday) yrs. <b>4</b> Months <b>18</b> Days <b>18</b>		10. IF UNDER 1 YEAR <b>4</b> Months <b>18</b> Days <b>18</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Malcolm CAGLE</b>		14. MOTHER'S MAIDEN NAME <b>Virginia POWER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Malcolm CAGLE (Father)</b>		Address <b>Alexandria, Va. 609 Cameron St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital heart disease - cyanotic</b> DUE TO (b) <b>754.4</b> DUE TO (c) <b>INTERVAL BETWEEN ONSET AND DEATH 4 mo</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pylorophritis, anemia, thrombocytopenia, bronchopneumonia</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>26 March 1956</b> to <b>3 April 1956</b> , that I last saw the deceased alive on <b>3 April 1956</b> , and that death occurred at <b>10:35 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Howard A. Pearson</b> M.D.		U.S. Naval Hospital, NMMC, Bethesda, Md.	
PHYSICIAN'S NAME (Type) <b>Howard A. PEARSON, LT, MC, USN</b>		U.S. Naval Hospital, NMMC, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5 April 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. PIMPHREY</b>		ADDRESS <b>Wisconsin Ave. 4-3-56</b>	
24a. REC'D BY REGISTRAR <b>4-3-56</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Connelley</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or any event within 72 hours after death.



4195

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>1 mo. 3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>				d. STREET ADDRESS <b>2005 Success Street</b>			
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Gerald</b> Last <b>CALDWELL</b>				4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 5 1953</b>	
9. AGE (In years last birthday) <b>2</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>							
13. FATHER'S NAME <b>William CALDWELL (Deceased)</b>				14. MOTHER'S MAIDEN NAME <b>Betty SMITH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Betty MORRISON, 2005 Success St., Charleston</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO (b) <b>Congenital heart disease (Tetralogy of Fallot)</b> DUE TO (c) <b>of Fallot</b>				INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>28 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>2 March</b> , 19 <b>56</b> , to <b>5 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5 April</b> , 19 <b>56</b> , and that death occurred at <b>6:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>J. Winthrop Peabody, Jr.</b>				PHYSICIAN'S NAME (Type) <b>J. Winthrop Peabody, Jr., LT, MC, U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-9-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Spartanburg, South Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. PUMPHREY, 7557 Wisconsin Ave.,</b>				24a. REC'D BY REGISTRAR <b>DATE 4-6-56</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Tassell</b>	

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, with the ward "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Pages 1, 2, and 3 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## 4196 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R-2</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Goshen Rd</u>		d. STREET ADDRESS <u>Goshen Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marjorie</u> Middle <u>Campbell</u> Last <u>Campbell</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-6-1905</u>
9. AGE (in years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR: Months <u>50</u> Days <u>50</u> Hours <u>50</u> Min. <u>50</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Washington Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Martha L. Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-30-1562</u>	
17. INFORMANT <u>no</u>		Address <u>no</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> (c) <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>4-9-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>April 11/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brookside</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery Co md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u>		24a. REC'D BY REGISTRAR <u>4-10-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>	

RECEIVED A. B.

SEP

1911



4197

CERTIFICATE OF DEATH

04168

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence</b>		d. STREET ADDRESS <b>1711 Sherwood Road.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Arthur T Cann</b>		4. DATE OF DEATH <b>April 3rd. 1956</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 15, 1894</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Boston, Mass</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Arthur Wendell Cann</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Monro</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.N. # 1.</b>	
17. INFORMANT <b>Ann T Cann</b>		Address <b>-1711 - Sherwood Road.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO <b>Coronary Occlusion -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arterio-sclerotic Heart Disease</b> DUE TO <b>Arterio-sclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 hr</b> <b>6 hr 5.</b> <b>10 years?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/3/56</b> to <b>4/3/56</b> , that I last saw the deceased alive on <b>4/3/56</b> , and that death occurred at <b>4/3/56</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William P. Frey</b>		M.D. <b>1150 Connelley Washington D.C.</b>	
PHYSICIAN'S NAME (Type) <b>William P. Frey</b>		ADDRESS (Street, city or town, state) <b>1150 Connelley Washington D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/7/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood</b>		22d. LOCATION (City, town, or county) (State) <b>Everett Mass</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>		ADDRESS <b>300 - 4 St N.E.</b>	
24a. REC'D BY REGISTRAR <b>DATE 4/6/56</b>		24b. REGISTRAR'S SIGNATURE <b>Frances Potter</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE OFFICE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the cause and date thereof should be stated in the space provided. The certificate, after being signed by the medical examiner, should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 20b Film 1956-1-13-28									
4155 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 04169 223									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				
c. LENGTH OF STAY IN 1b <u>40 min.</u>					d. STREET ADDRESS <u>1001 Hopewell Ave.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium &amp; Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Joseph</u> Last <u>Caputo</u> Jr.					4. DATE OF DEATH Month <u>4</u> - Day <u>29</u> Year <u>1956</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-13-39</u>		9. AGE (In years last birthday) <u>16</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Arthur J. Caputo Sr.</u>					14. MOTHER'S MAIDEN NAME <u>Josephine Caruso</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>—</u>				
17. INFORMANT <u>Father. Sam a Sten</u>					Address <u>—</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull</u> DUE TO <u>Ther.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thoracic hemorrhage</u> DUE TO <u>Crushed Chest</u> (c) <u>—</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH <u>—</u>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>—</u>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Involved in auto accident.</u>				
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>3:55</u> <u>4-29-1956</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>					20f. (City or town) <u>Hyattsville</u> (County) <u>P.E.</u> (State) <u>MD</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Frank J. Broschait</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>FRANK J. Broschait</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>May 2, 1956</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>					22d. LOCATION (City, town, or county) <u>Prince George's County</u> (State) <u>MD</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Walter</u>					24a. REC'D BY REGISTRAR <u>—</u>				
24b. REGISTRAR'S SIGNATURE <u>—</u>					24c. DATE <u>4-30-56</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4198

## CERTIFICATE OF DEATH

04170

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>2 hours</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		d. STREET ADDRESS <b>Route #2</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>(none)</b> Last <b>Catoe</b>		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> , Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 8, 1904</b>
9. AGE (In years last birthday) <b>52</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Labor work</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Catoe</b>		14. MOTHER'S MAIDEN NAME <b>Emma Stover</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>577-12-6074</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive hemorrhage; laceration of aorta</b> DUE TO (b) <b>Tracheo-esophageal fistula</b> DUE TO (c) <b>Carcinoma of esophagus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>15 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE: CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 11</b> , 19 <b>56</b> , to <b>April 11</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>April 11</b> , 19 <b>56</b> , and that death occurred at <b>1:25 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/12/56</b> ACTUAL SIGNATURE <b>Herbert J. Levine</b> M.D. PHYSICIAN'S NAME (Type) <b>Herbert J. Levine, M. D.</b> <b>The Clinical Center</b> <b>Bethesda 11, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/17/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park,</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>		ADDRESS <b>Rockville, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 4-18-56</b>		24b. REGISTRAR'S SIGNATURE <b>Dessie M. Thompson</b>	

BUREAU V. S.

APR 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04171

4199

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Hall Rest Home</b>		d. STREET ADDRESS <b>1340 "D" St., N.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>Belle</b> Last <b>CHANEY</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>19</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-4-78</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
13. FATHER'S NAME <b>John A. McLaughlin</b>		14. MOTHER'S MAIDEN NAME <b>Hannah J. Butler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>579-18-6184</b>	
17. INFORMANT <b>Robert L. Chaney- 9632 Old Spring Road</b>		<b>Kensington, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERTENSIVE HEART DISEASE</b> DUE TO (b) <b>ESSENTIAL HYPERTENSION</b> DUE TO (c) <b>GENERALIZED ARTERIO SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>JAN 25, 1955</b> to <b>APRIL 19, 1956</b> , that I last saw the deceased alive on <b>APRIL 19, 1956</b> , and that death occurred at <b>2:20 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Henry M. Lowden</b> M.D.		ADDRESS (Street, city or town, state) <b>5206 Norway Dr., Chevy Chase, Md.</b>	
DATE SIGNED <b>4/19/56</b>			
PHYSICIAN'S NAME (Type) <b>HENRY M. LOWDEN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-21-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>4/21/56</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

U. S. A.

1930

1930



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4200 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04172

Reg. Dist. No. 214

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8808 Old Bladensburg Road</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> <span style="float: right;">b. COUNTY <u>1</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> d. STREET ADDRESS <del>XXXXX</del> <u>1701 W St., S. E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ARTHUR</u> Middle <u>CHYATTE</u> Last <u>CHYATTE</u>				<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>22</u> Year <u>19 56</u>											
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Aug. 3, 1899</u>		<b>9. AGE</b> (In years last birthday) <u>56</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Owner</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Quick Car Wash</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Russia</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			
<b>13. FATHER'S NAME</b> <u>Kaseel Chyatte</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Ida Chyatte</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address <u>Mrs. Sophie Chyatte, 1701 W St., S. E.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage &amp; laceration</u> DUE TO (b) <u>bullet wound thru skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>												INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>shot by hold up man</u>											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>2:10</u> a-m. <u>4/22</u> 19 <u>56</u>				<b>20d. INJURY OCCURRED</b> While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Office</u>		<b>20f. (City or town)</b> <u>Silver Spring Md</u>		<b>(County)</b> <u>Montgomery</u>		<b>(State)</b> <u>Md</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>												<b>DATE SIGNED</b> <u>4-22-56</u>			
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. BROSCART</u> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>															
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>Apr. 24, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Geo. Wash. Mem. Cemetery</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>Hyattsville, Md.</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Goldberg Funeral Home</u> <b>ADDRESS</b> <u>4217 9th Street N.W.</u>												<b>24a. REC'D BY REGISTRAR</b> DATE <u>4/25/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Harold Potter</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, case examine the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 30 1956

BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the executor of the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 could be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04173/4  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In front of Shell Service Station Corner Pinay Branch & Greenwood Ave.				d. STREET ADDRESS 797 SEEK'S LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle MARION Last COLLINS		4. DATE OF DEATH Month APRIL Day 16 Year 19 56					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/14/88	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES COLLINS				14. MOTHER'S MAIDEN NAME MARTHA ALICE GIDDINGS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-12-1289		17. INFORMANT Address MRS. ELIZABETH ANN COLLINS, 7711 Greenwood Ave. Takoma Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sudden</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. EXAMINER'S NAME (Type) FRANK J. BROSCART				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4-16-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/20/56		22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. MEM. CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Warner E. Humphrey</u> , SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE 4/20/56		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4156

CERTIFICATE OF DEATH

04174

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. &amp; Hosp.</u>		d. STREET ADDRESS <u>5325 Chesapeake St.,</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby Girl</u> Middle <u>Condit</u> Last <u>Condit</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1956</u>
9. AGE (In years last birthday) yrs. <u>4</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Billy Monroe Condit</u>		14. MOTHER'S MAIDEN NAME <u>Johnnie Faye Hawkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital malformation of heart &amp; great vessels:</u> <u>754.4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>(Eisenmenger complex and coarctation of aorta, with bicuspid aortic &amp; pulmonic valves.)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Horseshoe kidney (congenital)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 8</u> , 19 <u>56</u> , to <u>Apr 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Apr 12</u> , 19 <u>56</u> , and that death occurred at <u>8:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ruth Standard</u> M.D.		ADDRESS (Street, city or town, state) <u>Wash San &amp; Hosp—</u> DATE SIGNED <u>4-13-56</u>	
PHYSICIAN'S NAME (Type) <u>Ruth Standard, M.D.</u>		Washington Sanitarium and Hospital.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>4-15-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium &amp; Hosp. Takoma Park, Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D.</u>		ADDRESS <u>Washington San. &amp; Hosp.</u>	
24a. REC'D BY REGISTRAR <u>DATE 4-16-56</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dods</u>	

7 1956

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4202 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04175

Reg. Dist. No. *216*

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i> c. LENGTH OF STAY IN TB <i>53 yrs</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>3602 Spring St</i>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montg</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i> d. STREET ADDRESS <i>3602 Spring St</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <i>John Merrill Conner</i>		<b>4. DATE OF DEATH</b> Month Day Year <i>Apr 2 1956</i>		<b>5. SEX</b> <i>M</i>		<b>6. COLOR OR RACE</b> <i>W</i>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <i>Feb 21 1901</i>		<b>9. AGE</b> (In years last birthday) <i>55 yrs</i>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Real Estate</i>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Pa</i>				<b>11. BIRTHPLACE</b> (State or foreign country) <i>Pa</i>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>					
<b>13. FATHER'S NAME</b> <i>L. Conner</i>						<b>14. MOTHER'S MAIDEN NAME</b> <i>Mabel Stone</i>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service)				<b>17. INFORMANT</b> <i>Mrs. Eda C. Conner (wife)</i>				Address <i>Demarest St 2</i>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ (c) _____														INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <i>19</i>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
<b>ACTUAL SIGNATURE</b> <i>Frank J. Brochert</i> M.D.								<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b>					
<b>EXAMINER'S NAME (Type)</b> <i>Frank J. Brochert</i>								<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>burial</i>				<b>22b. DATE THEREOF</b> <i>4/6/56</i>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <i>Arlington Nat. Cemetery</i>				<b>22d. LOCATION</b> (City, town, or county) (State) <i>Arlington, Virginia</i>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Thos. N. Hema Co</i>								<b>24a. REC'D BY REGISTRAR</b> <i>4-4-56</i>				<b>24b. REGISTRAR'S SIGNATURE</b> <i>Bessie M. Thompson</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the cause of death should be stated on the certificate, and the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

THOMAS V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4203

## CERTIFICATE OF DEATH

Reg. Dist. No.

04176

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>17 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		d. STREET ADDRESS <u>6006 36th Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Clinical Center, N.I.H.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Estelle</u> Middle <u>Edwards</u> Last <u>Conover</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 20, 1881</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kansas</u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Oscar Herron</u>		14. MOTHER'S MAIDEN NAME <u>G race Tharp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Medical Record - Clinical Center, N.I.H.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, rt lung</u> DUE TO (b) <u>Gangrene, left arm</u> (c) <u>Carcinoma, left breast with metastases to spine, ribs, sternum and pleurae</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 days</u> <u>28 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 11</u> , 19 <u>56</u> , to <u>April 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 28</u> , 19 <u>56</u> , and that death occurred at <u>5:03 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Clinical Center, Bethesda, Md</u> <u>April 29 '56</u>			
ACTUAL SIGNATURE <u>Allan Henry Levy, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Allan Henry Levy, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/1/56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>WINFIELD, KANSAS</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalleys Funeral Home - 3200 R.I. AVE.</u>		ADDRESS <u>MT. RAINIER, MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE 4/30/56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04177

## 4204 CERTIFICATE OF DEATH

Reg. Dist. No. 216

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Montgomery</u>		STATE <u>Md.</u> COUNTY <u>Montgomery</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location)		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH		5. SEX		6. COLOR OR RACE	
(First) <u>Mary</u> (Middle) <u>Ridgway</u> (Last) <u>Cook</u>		(Month) <u>April</u> (Day) <u>9th</u> (Year) <u>1956</u>		Female		White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec., 27, 1884</u>		9. AGE last birthday <u>71</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Front Royal, Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Otho G. Ridgway</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Brown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Lester B. Cook, 5600 Saratoga Ave.,</u>		18. MEDICAL CERTIFICATION		19. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		IMMEDIATE CAUSE (A) <u>Cerebrovascular Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>		ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Disease</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/9</u> to <u>4/9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/9</u> , 19 <u>56</u> , and that death occurred at <u>3:59 PM</u> , from the causes and on the date stated above.		23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 11, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>WASH. MEMORIAL PARK</u>	
24. REC'D BY REGISTRAR <u>Bessie M. Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>CHEVY CHASE FUNERAL HOME</u>		ADDRESS (Street, city, town, state) <u>5103 WISE AVE NW DC 16</u>		DATE SIGNED <u>4/9/56</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04178

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

4205

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN IB <b>5 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center</b> <b>National Institutes of Health</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Vernon</b> Middle <b>Pierce</b> Last <b>Crane</b>				4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 4, 1914</b>	
9. AGE (In years last birthday) <b>41</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>12</b> Hours <b>56</b> Min.		IF UNDER 24 HRS Months <b>4</b> Days <b>12</b> Hours <b>56</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Govt. Employee</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Information Agency</b>			
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Leroy Crane</b>				14. MOTHER'S MAIDEN NAME <b>Edith Pierce</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>357-09-0182</b>			
17. INFORMANT <b>The medical record</b> <b>The Clinical Center</b>				Address <b>Bethesda, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic Heart Disease with</b> <b>410X</b> DUE TO <b>Mitral Valvular Disease and</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Congestive Heart Failure</b> (c) <b>14 yrs.</b> <b>2 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 7, 1956</b> , to <b>April 12, 1956</b> , that I last saw the deceased alive on <b>April 12, 1956</b> , and that death occurred at <b>8:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John T. Binion</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>John T. Binion, M. D.</b>				DATE SIGNED <b>4/13/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 16, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington County Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. P. Jones (mrs)</b>				24a. REC'D BY REGISTRAR DATE <b>4/14/56</b>			
ADDRESS <b>Arlington 1, Va.</b>				24b. REGISTRAR'S SIGNATURE <b>Bessie D. Thompson</b> <b>Per D.H.</b>			

U. S. V.

APR 12 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

04179  
Reg. Dist. No. 223

4157

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>N.J.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park Md</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp.</u>		d. STREET ADDRESS <u>Rd 1 Box 213</u>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Susie</u> Last <u>Creveling</u>		4. DATE OF DEATH Month <u>4</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-1903</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Peoplesdorph</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Edmonds</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Washington Sanitarium Hospital, Takoma Park, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr. Obstruction of colon</u> DUE TO <u>Adenocarcinoma of rectum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>&amp; metastasis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u> <u>18 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar. 29, 1955</u> to <u>Apr. 12, 1956</u> that I last saw the deceased alive on <u>Apr. 11, 1956</u> and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul V. Starr</u> M.D.		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave. Apt. 12, 1956</u>	
PHYSICIAN'S NAME (Type) <u>Takoma Park, Md.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>4-14-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Natl. Mem. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Falls Church Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers &amp; Co. 1401 Chapin NW</u>		24a. REC'D BY REGISTRAR <u>4/14/56</u>	24b. REGISTRAR'S SIGNATURE <u>William D. Doherty</u>

U.S.

PR 17 1955

U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4172

CERTIFICATE OF DEATH

Reg. Dist. No. 04180

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1203 Clagett Drive</b>		d. STREET ADDRESS <b>1203 Clagett Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MAMIE</b> First Middle Last		4. DATE OF DEATH <b>April 26, 1956</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 5, 1892</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>21</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Dan Zirkle</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Wm. R. Curtis-Item # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIAL HYPERTENSION</b> DUE TO (c) <b>CONGESTIVE HEART FAILURE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>15 YEARS</b> <b>TWO YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>LEFT LUNG COLLAPSE SURGICAL - OLD TUBERCULOSIS</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>MARCH 30, 1956</b> to <b>APRIL 26, 1956</b> that I last saw the deceased alive on <b>APRIL 25, 1956</b> , and that death occurred at <b>3:30 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>310 West MONTGOMERY AVE. ROCKVILLE, MARYLAND</b> DATE SIGNED <b>APR 26, 1956</b>			
ACTUAL SIGNATURE <b>Gordon S. Rosenberger, M. D.</b>		SIGNATURE OF REGISTRAR <b>Laurel H. Kraybill</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-29-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Grove Church Cemetery</b>
22d. LOCATION (City, town, or county) (State) <b>Goldvein, Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>4/30/56</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 2 1956

RECEIVED

4/30/56

## MARYLAND STATE DEPARTMENT OF HEALTH

04181

2411 N. Charles Street, Baltimore

4173

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Laird St.</u>		STREET ADDRESS (If rural, give location) <u>10 Laird St.</u>	
3. NAME OF DECEASED (Type or Print) <u>JULIA</u> (First) <u>I</u> (Middle) <u>DARBY</u> (Last)		4. DATE OF DEATH <u>April</u> (Month) <u>29</u> (Day) <u>1956</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>March 16 1891</u>
9. AGE last birthday <u>65</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Thomas Jefferson Palbert</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hanson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Thomas Darby (Same)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusionAntecedent cause(s) (b) Malignancy of neoplasiaDiseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Carcinoma of left breast

INTERVAL BETWEEN ONSET AND DEATH

15 minutes6 months10 years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION <u>1946</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of left breast (Radical mastectomy)</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>INJURY</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Rockville, Md.</u>	CITY OR TOWN <u>Rockville, Md.</u> COUNTY <u>Montgomery</u> (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>April 29 1956</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Car accident</u>

22. I hereby certify that I attended the deceased from 1946 to April 29, 1956, that I last saw the deceasedalive on April 29, 1956, and that death occurred at 5:30 p.m., from the causes and on the date stated above.SIGNATURE W. H. Finkbeiner, M.D.

(Degree or title)

ADDRESS Rockville, Md.DATE SIGNED April 29/56

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 2, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Damascus</u>	LOCATION (City, town, or county) <u>Damascus Maryland</u> (State)
DATE REC'D BY LOCAL REG. <u>5/2/56</u>	REGISTRAR'S SIGNATURE <u>Lamell H. Knight</u>	24. FUNERAL DIRECTOR <u>Roy W. Barber, Laytonville, Md.</u>	ADDRESS <u>Laytonville, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

MAY 3 1950

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4206

## CERTIFICATE OF DEATH

04182

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>		d. STREET ADDRESS <b>1920 S. Street, N. W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>Ferry</b> Last <b>Dawley</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 28, 1883</b>
9. AGE (In years last birthday) yrs. <b>72</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Francis Ferry</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Stark</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>The medical record,</b> Address <b>The Clinical Center, N.I.H. Bethesda, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>hypercalcemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>bone metastases</b> DUE TO (c) <b>carcinoma breast</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 17, 1956</b> , to <b>April 21, 1956</b> , that I last saw the deceased alive on <b>April 21, 1956</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Mehran Goudian</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b>	
PHYSICIAN'S NAME (Type) <b>Mehran Goudian</b>		DATE SIGNED <b>4/21/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>4-21-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln Cemetery</b>		22d. LOCATION (City, town, county) (State) <b>Prince Georges Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>2901 14th St. N.E.</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

RECEIVED V. S.

APR

## 4207 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Montgomery</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Montgomery</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Chevy Chase</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Chevy Chase</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>6812 Meadow Lane</b>				STREET ADDRESS (If rural give location) <b>6812 Meadow Lane</b>			
3. NAME OF DECEASED (Type or Print) <b>JOHN S DELANO</b>				4. DATE OF DEATH <b>April 29, 1956</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>		8. DATE OF BIRTH <b>6-30-1889</b>	
				9. AGE last birthday <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive - Pres. Amer. Pilots Ass'n.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Joseph Delano</b>				14. MOTHER'S MAIDEN NAME <b>Ida Snyder</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>218-32-0490</b>		17. INFORMANT & ADDRESS <b>Mrs E.S. Lazowska 2926 Tennyson St NW Wash. DC</b>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Coronary Occlusion (Thrombosis) 4/29/56</b>							
ANTECEDENT CAUSE(S) DUE TO (B) <b>Cerebral Thrombosis (Hemiplegia)</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <b>Attacks of Cardiac Angina</b>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Aug 19, 1944</b> to <b>Apr 22, 1956</b> that I last saw the deceased alive on <b>Apr 22, 1956</b> and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Joseph M. Thompson</b>				ADDRESS (Street, city, town, state) <b>2601 Roadway Pl. N. H. Wash. D.C.</b>		DATE SIGNED <b>4/29/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>5/2/1956</b>		NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>	
24. REC'D BY REGISTRAR <b>5/3/56</b>		REGISTRAR'S SIGNATURE <b>Beaser M. Thompson</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph M. Thompson</b>		ADDRESS <b>1756 14th St. N.W.</b>	

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

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7 1956

107E



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**4208**  
**CERTIFICATE OF DEATH**

**04184**

Reg. Dist. No. **216**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>8 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Montgomery</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield</b> d. STREET ADDRESS <b>5719 Ogden Rd.</b> e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Mrs. Hettie W. Dodge</b>				<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>20</b> Year <b>1956</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Dec. 26 1883</b>		<b>9. AGE</b> (In years last birthday) <b>72</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Secretary</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Govt.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Washington D.C.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>John G. Weigel</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Louisa Kraft</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Louise D. Moore</b>		Address <b>Springfield, Md. 5719 Ogden Rd.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute</b> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary thrombosis, left</b> DUE TO _____ (c) <b>Coronary arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>9<sup>+</sup> days</b> <b>10<sup>+</sup> yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rupture interventricular Septum</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>of heart</b>				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19 <b>56</b>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <b>12/1, 1955</b> , to <b>4/20, 1956</b> , that I last saw the deceased alive on <b>4/20, 1956</b> , and that death occurred at <b>5:55 PM</b> , from the causes and on the date stated above.									
<b>ACTUAL SIGNATURE</b> <b>Frank Jagers</b> M.D.				<b>ADDRESS</b> (Street, city or town, state) <b>5707 Wisconsin Ave 4/21/56</b> <b>Cherry Chase 15 Md</b>					
<b>PHYSICIAN'S NAME</b> (Type) <b>Frank Jagers</b>				<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Cremation</b>					
<b>22b. DATE THEREOF</b> <b>4-23-56</b>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Suitland, Maryland</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey-Bethesda, Maryland</b>						<b>24a. REC'D BY REGISTRAR</b> <b>DATE 4-22-56</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Bessie M. Thompson</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1956

RECEIVED



BUREAU V. S.

APR 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4210

CERTIFICATE OF DEATH

041865

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> <b>West Virginia</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Rural</b>		c. LENGTH OF STAY IN 1b <b>3 hrs 24 min</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>-- 7521 Forest Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Rudolph</b> Last <b>DUMIRE</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-21-56</b>
9. AGE (In years last birthday) yrs. <b>3</b>		IF UNDER 1 YEAR Months <b>24</b> Days <b>3</b> Hours <b>24</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>James E. DUMIRE</b>		14. MOTHER'S MAIDEN NAME <b>Angie V. TURNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-- --</b>	
17. INFORMANT Address <b>Father James E. DUMIRE SAME AS #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>776X Prematurity</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Apnea Neonatorum</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 24</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-21-</b> , 19 <b>56</b> , to <b>4-21-</b> , 19 <b>56</b> that I last saw the deceased alive on <b>4-21</b> , 19 <b>56</b> , and that death occurred at <b>4:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>USNH, NMMC, Bethesda, Maryland</b> DATE SIGNED <b>4-21-56</b>			
ACTUAL SIGNATURE <b>H. A. Pearson</b>		M.D. <b>USNH, NMMC, Bethesda, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>H. A. PEARSON LT, MC, USN</b>		<b>USNH, NMMC, Bethesda, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>25 Apr 56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>24b. REGISTRAR'S SIGNATURE <b>Mary E. Parnell</b></b>	
ADDRESS <b>7557 Wisconsin Avenue, Beth</b>		<b>Md. 21 Apr 56</b>	

RECEIVED

APR 24 1956

BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4211

CERTIFICATE OF DEATH

Reg. Dist. No.

04187  
278

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5800 Anniston Road</b>		d. STREET ADDRESS <b>5800 Anniston Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>PRESTON</b> Middle <b>B.</b> Last <b>DUNBAR</b>		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> , Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 26, 1893</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR: Months <b>11</b> Days <b>15</b> Hours <b>5</b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Reuben H. Dunbar</b>		14. MOTHER'S MAIDEN NAME <b>Laura Clark</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW 1</b>		16. SOCIAL SECURITY NO. <b>577-03-4982</b>	
17. INFORMANT <b>Anne E. Dunbar-Item# 2</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>13 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> P. M. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 1945</b> to <b>April 1956</b> that I last saw the deceased alive on <b>April 10</b> , 1956, and that death occurred at <b>11:54</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leo J. Donovan M.D.</b>		ADDRESS (Street, city or town, state) <b>5016 Perogaton Rd Bethesda, Md.</b>	
DATE SIGNED <b>4/11/56</b>			
PHYSICIAN'S NAME (Type) <b>LEO J DONOVAN M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-16-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		ADDRESS <b></b>	
24a. REC'D BY REGISTRAR <b>DATE 4/14/56</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>	

1947



CERTIFICATE OF DEATH

Reg. Dist. No. 215

4212

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Virginia Beach</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Virginia Beach</b>	
c. LENGTH OF STAY IN 1b <b>4 days</b>		d. STREET ADDRESS <b>Bay Colony Drive</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Pittard</b> Last <b>EDWARDS</b>		4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 Oct. 1913</b>
9. AGE (In years last birthday) <b>42 yrs.</b>		IF UNDER 1 YEAR Months <b>17</b> Days <b>12</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Harry F. PITTARD</b>		14. MOTHER'S MAIDEN NAME <b>Estelle E. MURRELLE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Captain David S. EDWARDS, (Same as #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism with Cardiac Arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Postoperative Mitral Commissurotomy</b> DUE TO (c) <b>Rheumatic Heart Disease</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>24 hours</b> <b>Indefinite</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>22 April</b> , 19 <b>56</b> , to <b>26 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>26 April</b> , 19 <b>56</b> , and that death occurred at <b>2:09 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>4-27-56</b> ACTUAL SIGNATURE <b>C. S. Durden Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>C. S. DURDEN Jr. LT, MC, USN</b> <b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1 May 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawler's &amp; Sons, 1756 Penn Ave., Wash. DC.</b>		24a. REC'D BY REGISTRAR <b>4-27-56</b>	
24b. REGISTRAR'S SIGNATURE <b>May E. Parrelly</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

BUREAU V. S.

APR 20 1950

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04189

4213

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>1 1/2</u> hours			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John William Elliott</u>				4. DATE OF DEATH Month Day Year <u>4-17 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-16</u>		9. AGE (In years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>construction work</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles E. Elliott</u>				14. MOTHER'S MAIDEN NAME <u>Ida Louise Gates</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>World War II</u>		17. INFORMANT <u>Amy Rabbitt--sister</u>		Address <u>Washington Ave., Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO <u>Multiple fracture ribs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fracture base of skull and right femur</u> DUE TO <u>Struck by train</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 hours</u> <u>2 hours</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian struck by B+O train Rockville Monty Md</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>5:30</u> p.m. <u>4-17 1956</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> <u>B+O R.R.</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rockville Monty Md</u>		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4-18-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>4-18-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, the case executive the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4214

## CERTIFICATE OF DEATH

04190  
2/6

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>8600 Old Georgetown Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Lavinia</u> Last <u>Fisher</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 24, 1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>26</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse's aide</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>Thomas McGaha</u>				14. MOTHER'S MAIDEN NAME <u>Martha Lavinia Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Raymond C. Fisher-200 Horners Lane, Rockv. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage on left</u> 331X - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral artery sclerosis</u> DUE TO (c) <u>Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>7 yrs</u> <u>15 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <u></u> Not while <u></u> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>18 April, 1956</u> to <u>20 April, 1956</u> , that I last saw the deceased alive on <u>19 April, 1956</u> , and that death occurred at <u>1:35 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Merton L. White</u> M.D.				ADDRESS (Street, city or town, state) <u>11134 George Ave, Hkt 20, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Merton L. White M.D.</u>				DATE SIGNED <u>4/21/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/22/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Potomac Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Potomac Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>7557 Wis. Ave. Beth. Md.</u>		24a. REC'D BY REGISTRAR <u>4/21/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

THE A. J. J. J.

1956

19

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TO REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the registrar or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4215

## CERTIFICATE OF DEATH

04191

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>Route 3, Congraft Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Yates</u> Last <u>Forrester</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 5, 1884</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>21</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conciliator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Labor</u>		11. BIRTHPLACE (State or foreign country) <u>Worcester, Mass.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph E. Yates</u>				14. MOTHER'S MAIDEN NAME <u>Mary Casey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Niece, Mrs. David DeWiler</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Thrombosis right coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis Coronary</u> DUE TO (c) <u>Early Bronchopneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u> <u>? years</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Early Bronchopneumonia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>1953</u> to <u>26 April, 1956</u> , that I last saw the deceased alive on <u>26 April, 1956</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. S. Murphy</u>				ADDRESS (Street, city or town, state) <u>M.D. 665 W. Mount Pleasant Rd. Rockville, Md. 280</u>			
PHYSICIAN'S NAME (Type) <u>W. S. Murphy</u>				DATE SIGNED <u>28 April 56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 30, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 29-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

U. S. A. 1931

1931



MARYLAND

4216

## CERTIFICATE OF DEATH

04192  
STATE DEPARTMENT OF HEALTH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> TOWN <u>3 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> TOWN <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8511 Old Bladensburg Rd</u>		STREET ADDRESS (If rural, give location) <u>8511 Old Bladensburg Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Adele</u> (First) (Middle) (Last) <u>Gadol</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr 1 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Nov 25 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>66</u> yrs. If under 1 year: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Romania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>None</u>		14. MOTHER'S MAIDEN NAME <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Ellis Gadol Silver Spring, Md.</u>			

18. MEDICAL CERTIFICATION  
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

171X Immediate cause (a) Metastatic Carcinoma

Antecedent cause(s) (b) ? Carcinoma of Cervix ?

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) None

INTERVAL BETWEEN ONSET AND DEATH

8 mo.

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>None</u>	(CITY OR TOWN) <u>Silver Spring</u>	(COUNTY) <u>Montg.</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>None</u>		

22. I hereby certify that I attended the deceased from Nov, 1955, to Apr 1, 1956, that I last saw the deceasedalive on Apr 1, 1956, and that death occurred at 7:45 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

1 A. F. Thibodeau and John L. Avery MD 10110 Georgia Ave. Silver Spring Md 4/1/5623. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 4-3-56

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

James L. Avery Gretheg Funeral Home - 4217-9 St. X

MARGIN RESERVED FOR BINDING

U.S. AIR FORCE

## 4217 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>10 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chesley Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Resmor Hospital</u> <u>5721 Grosvenor Lane</u>		STREET ADDRESS (If rural give location) <u>3907 Virginia St.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Edith</u>	(Middle) <u>Mary Weston</u>	(Last) <u>Gagge</u>	(Date) <u>April 19 1956</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Oct. 20, 1878</u>
9. AGE last birthday: <u>77</u> yrs.		10. IF UNDER 1 YEAR: <u>5</u> Months <u>29</u> Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Ipswich, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Arthur Smith</u>		14. MOTHER'S MAIDEN NAME: <u>MARIA Jakes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO.: <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>3907 Virginia St.</u> <u>Col. A.P. Gagge - Chesley Chase, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>metastatic Carcinoma of</u>			
ANTECEDENT CAUSE (B) <u>Breast, widespread</u>		<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>Carcinoma of Breast</u>	
		<u>10+ years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/9</u> , 19 <u>55</u> , to <u>4/19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/15</u> , 19 <u>55</u> , and that death occurred at <u>9:16</u> A.M. from the causes and on the date stated above.			
SIGNATURE <u>Charles J. Savarese Jr.</u>		M.D. <u>4861 Battery Pa Beth, Md.</u> <u>4/19/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial-transit</u>	<u>4/20/1956</u>	<u>Hollywood</u>	<u>Henrico Co. Virginia</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4/21/56</u>	<u>Bessie M. Thompson</u>	<u>Robert A. Pumphrey</u>	<u>Bethesda, Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 25 1955

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4218

## CERTIFICATE OF DEATH

Reg. Dist. No. 04194

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		d. STREET ADDRESS <u>1022 RUATAN STREET.</u>	
3. NAME OF DECEASED (Type or print) First <u>GENEVA</u> Middle <u>B.</u> Last <u>GALLOWAY</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1916</u>
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE MALBY</u>		14. MOTHER'S MAIDEN NAME <u>CLAMZY CARVER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-38-0716</u>	
17. INFORMANT <u>JAMES E. Galloway</u> Address <u>1052 RUATAN ST. SS MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MYOCARDIAL Infarction</u> DUE TO (c) <u>CORONARY Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 HOURS</u> <u>3 Days</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>12:15 P.m. April 28 1956</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 25, 1956</u> to <u>April 28, 1956</u> that I last saw the deceased alive on <u>April 28, 1956</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jack Crowell</u>		M.D. <u>2025 Eye St., N.W. Wash., D.C.</u>	
PHYSICIAN'S NAME (Type) <u>JACK CROWELL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/1/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BURTONSVILLE UNION CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>3/30/56</u> 24b. REGISTRAR'S SIGNATURE <u>Frances Latier</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

BUREAU V. S.

1956

7

RECEIVED

INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4219

CERTIFICATE OF DEATH

Reg. Dist. No. 04195

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>VIRGINIA</b> b. COUNTY <b>FAIRFAX</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. NAVAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED * (Type or print) First Middle Last <b>LOIS DOROTHY GARBUSCHEWSKI</b>		4. DATE OF DEATH Month Day Year <b>APRIL 20 1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-27-27</b>
9. AGE (In years last birthday) yrs <b>29</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>29</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>CALIFORNIA</b>	
11c. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CHESTER HILL DEC.</b>		14. MOTHER'S MAIDEN NAME <b>DOROTHY SINGLETON DEC.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>549 302 774</b>	
17. INFORMANT <b>HORST GARBUSCHEWSKI</b>		Address: <b>FALLS CHURCH VA.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cereurysm, Basilar Artery &amp; hemorrhage</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>19 APRIL</u> , 19 <u>56</u> , to <u>20 APRIL</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>20 APRIL</u> , 19 <u>56</u> , and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>USNH, NMMC, Bethesda, Maryland 4-20-56</b>			
ACTUAL SIGNATURE <u>R.W. Mackie</u>		M.D. <u>USNH, NMMC, Bethesda, Maryland</u>	
PHYSICIAN'S NAME (Type) <b>R.W. MACKIE CDR MC USN</b>		U.S. NAVAL HOSPITAL NMMC BETHESDA MD.	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>26 Apr 56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>RIVerview CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>ST. JOSEPH MICHIGAN</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. PUMPHREY</b>		ADDRESS <b>BETHESDA, MD</b> <b>7557 WISCONSIN AVE</b>	
24a. REC'D BY REGISTRAR <b>21 Apr 56</b>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Pumphrey</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 24 1956

BUREAU V. S.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4220

## CERTIFICATE OF DEATH

04196

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colesville</b>		c. LENGTH OF STAY IN 1b <b>15</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Colesville</b>		d. STREET ADDRESS <b>Box 103 Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>Irene</b> Last <b>Gates</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 12 1901</b>
9. AGE (In years last birthday) yrs. <b>54</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>		13. FATHER'S NAME <b>Algernon Johnson</b>	
14. MOTHER'S MAIDEN NAME <b>Mary E. Grimsley</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>#####</b> (If yes, give year or date of service) <b>#####</b>	
16. SOCIAL SECURITY NO <b>216 18 0782</b>		17. INFORMANT Address <b>George A. Gates, Box 103 Silver Spring</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Glioblastoma multiforme of brain</b> 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>12-15 mo.</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 20, 1956</b> , to <b>April 6, 1956</b> , that I last saw the deceased alive on <b>April 6, 1956</b> , and that death occurred at <b>2:10 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D. Aud</b>		ADDRESS (Street, city or town, state) <b>9006 Colavll. Rd, Silver Spring</b>	
DATE SIGNED <b>4-10-56</b>		24b. REGISTRAR'S SIGNATURE <b>Lester B. Lowly</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 9 56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Jennings Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Howard Co. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Roy W. Barber</b>		ADDRESS <b>Laytonsville, Md.</b>	

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17.007

4221

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Montgomery</u> STATE <u>Maryland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp.</u>				d. STREET ADDRESS <u>8215 Garland Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Gillespie</u> Last <u>Gillespie</u>				4. DATE OF DEATH Month <u>Apr-</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>M-</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 15 - 1865</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
13. FATHER'S NAME <u>Gillespie</u>				14. MOTHER'S MAIDEN NAME <u>Cunningham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>156-10-8681A</u>			
17. INFORMANT <u>Daughter</u>				18. ADDRESS <u>8215 Garland Ave. Takoma Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Sub-Arachnoid Hemorrhage</u> DUE TO <u>Sen. Arteriosclerotic Cardia</u> DUE TO <u>Vascular Lesions + Hypertension</u> DUE TO <u>443x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Apr. 3, 1956</u> to <u>Apr. 10, 1956</u> that I last saw the deceased alive on <u>Apr. 10, 1956</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Basley Ziegler</u> M.D.				DATE SIGNED <u>4-10-56</u>			
PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>				ADDRESS <u>Olney, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit Burial</u>				22b. DATE THEREOF <u>April 12, 1956</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Vineland, New Jersey</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St. NW Apt 40</u>				24a. REC'D BY REGISTRAR DATE <u>4-17-56</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur B. Bowler</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 1 1911

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

4222

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		d. STREET ADDRESS <b>8201 Kentbury Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Newell</b> Middle <b>Canfield</b> Last <b>Granger</b>		4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-13-04</b>
9. AGE (In years last birthday) <b>52</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>1</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Architect</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Arthur L. Granger</b>		14. MOTHER'S MAIDEN NAME <b>Annie West</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Wife</b>		Address <b>Gertrude P. Granger 8201 Kentbury Dr. Beth. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary occlusion -</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary arterio sclerosis</b> DUE TO (c) <b>arterio sclerosis generalised</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 11, 1956</b> to <b>April 14, 1956</b> that I last saw the deceased alive on <b>April 14, 1956</b> , and that death occurred at <b>3:20</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Alfred S. Norton</b>		ADDRESS (Street, city or town, state) <b>4711 Highland Ave., Bethesda, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Alfred S. Norton</b>		DATE SIGNED <b>4/14/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>	22b. DATE THEREOF <b>4-17-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Kensico Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>West Chester Co., N. Y.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR <b>4-17-56</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

MEDICAL CERTIFICATION

Burial-Transit

7557 Wisconsin Ave

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 20 1956

4223

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NMMC, Bethesda, Md.</b>		d. STREET ADDRESS <b>6903 Baltimore Ave.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Noah</b> Middle <b>(n)</b> Last <b>GULLETT</b>		4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 2, 1874</b>
9. AGE (In years full birthday) yrs. <b>82</b>		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lawyer</b>	
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>William GULLETT (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Julia Hungerford (Deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>(Son) William W. GULLETT (Same as #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>G</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 April</b> , 1956, to <b>24 April</b> , 1956, that I last saw the deceased alive on <b>24 April</b> , 1956, and that death occurred at <b>9:50 A.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dominic A. Brancazio</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Dominic A. Brancazio, LT, MC, USNR U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-28-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elizabethtown, Illinois</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. PUMPHREY</b> ADDRESS <b>Bethesda, Md. 7557 Wisc. Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>4-24-56</b>	
		24b. REGISTRAR'S SIGNATURE <b>Ray E. Cassally</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

APR 26 1956

RECEIVED



4224

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville (Rural)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>74 Serbanow Hosp</i>		d. STREET ADDRESS <i>RFD</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>CLARENCE W. HALLER</i>		4. DATE OF DEATH Month Day Year <i>April 30 1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>29 April 56</i>
9. AGE (In years last birthday) yrs. <i>19</i>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Clarence Haller</i>		14. MOTHER'S MAIDEN NAME <i>Wonda Fink</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Father-Item # 2</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> <i>773.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>immaturity</i> (c) <i>prematurity</i>			INTERVAL BETWEEN ONSET AND DEATH <i>19 hrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>29 April, 1956</i> , to <i>30 April, 1956</i> , that I last saw the deceased alive on <i>29 April, 1956</i> , and that death occurred at <i>12:41</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Vincent L. O'Donnell</i> M.D.		ADDRESS (Street, city or town, state) <i>8218- Wisc Ave Beth 30 April</i>	
PHYSICIAN'S NAME (Type) <i>Vincent L. O'Donnell</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-5-3-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parson</i>	22d. LOCATION (City, town, or county) (State) <i>Parson, W. Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i>		24a. REC'D BY REGISTRAR <i>4/30/56</i> 24b. REGISTRAR'S SIGNATURE <i>Beaie M. Thompson</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAY 2 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4225  
CERTIFICATE OF DEATH

04201  
216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>3273 Prospect Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Hammond</u> Last <u>Hammond</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1913</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frank Hamernan</u>	
14. MOTHER'S MAIDEN NAME <u>Eva Apter</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>114-10-3995</u>		17. INFORMANT <u>Paul Burman</u> Address <u>2921 Greenvale Rd. Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/16/56</u> , 19 <u>56</u> , to <u>4/16/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/16/56</u> , 19 <u>56</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen D. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>Rothville Md</u> DATE SIGNED <u>4/16/56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-18-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAKHILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WASH, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u> ADDRESS <u>3072 M. St. N.W.</u>		24a. REC'D BY REGISTRAR <u>Rebecca Thompson</u> DATE	24b. REGISTRAR'S SIGNATURE

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APR 18 1956

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4158

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

### 04202

Reg. Dist. No. 223

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Maryland</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>216 Grant Ave</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>216 Grant Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Patrick</u> Middle <u>Francis</u> Last <u>Hart</u>				<b>4. DATE OF DEATH</b> Month <u>Apr</u> Day <u>16</u> Year <u>1956</u>													
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 9 1962</u>		<b>9. AGE</b> (In years last birthday) <u>93</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Electrician</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Furniture</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Ireland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USC</u>					
<b>13. FATHER'S NAME</b> <u>Not Available</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Not Available</u>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b> <u>471-10-9571A</u>				<b>17. INFORMANT</b> <u>Joe M. Hart (son)</u>				Address <u>1502</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS</b> PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		(County)		(State)					
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
<b>ACTUAL SIGNATURE</b> <u>Frank J. Brzezinski</u> M.D.						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DATE SIGNED</b> <u>4-16-56</u>					
<b>EXAMINER'S NAME (Type)</b> <u>Frank J. Brzezinski</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>											
						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>TRANSIT BURIAL</u>				<b>22b. DATE THEREOF</b> <u>APR. 21, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Michael's Cemetery</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Stillwater Minnesota</u>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Arthur Walters, 254 Carroll St NW DC</u>														<b>24a. REC'D BY REGISTRAR</b> <u>4/18/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>John N. ...</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

BUREAU V. S.

APR 19 1956

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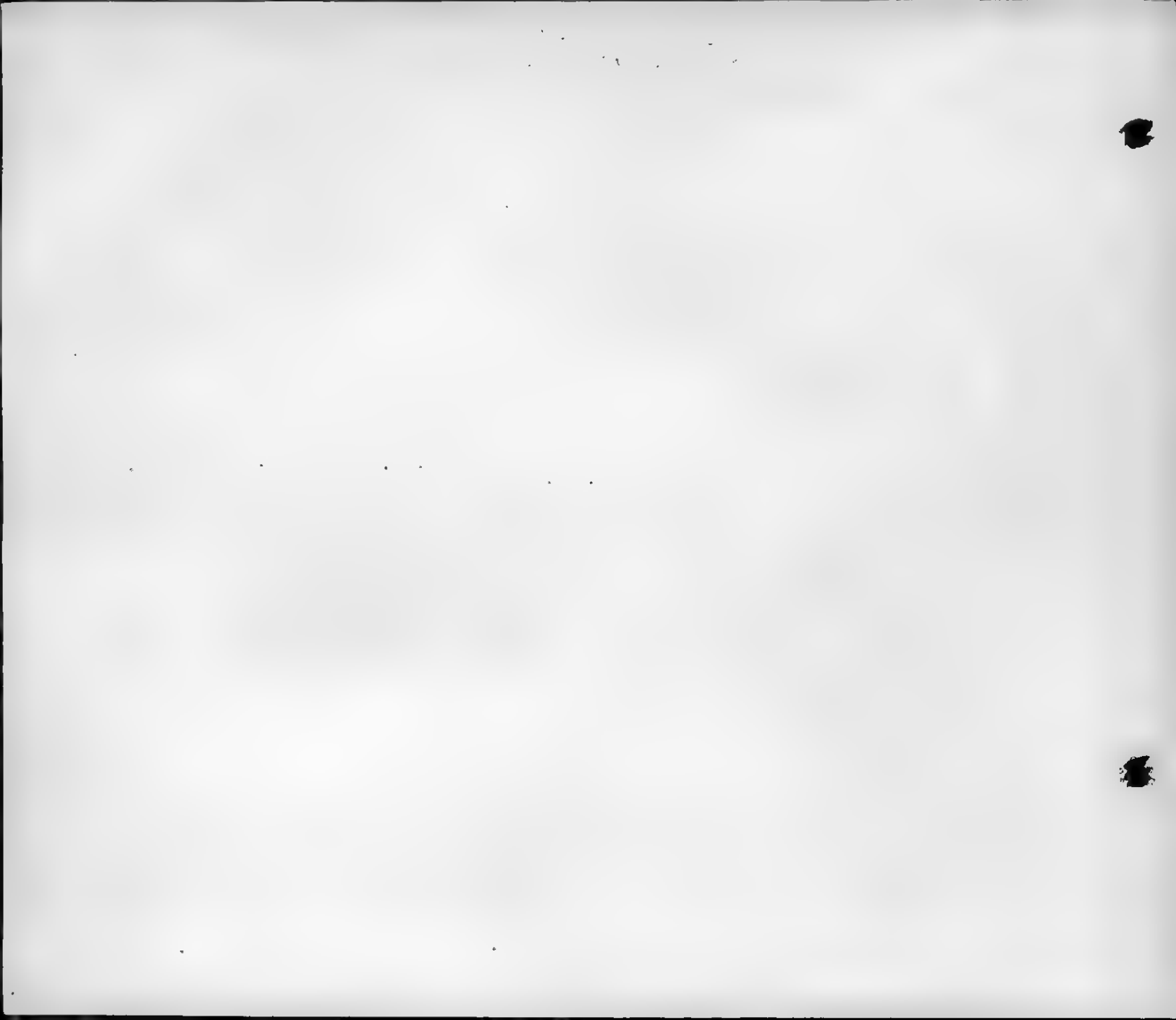
## CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH. <u>Asbury mzh. Home</u> COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Griffithsburg</u> LENGTH OF STAY (in this place) <u>7 years</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Asbury mzh. Home</u> <u>Saithsburg Md.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Saithsburg</u> STREET ADDRESS (If rural give location) <u>Rolling Acres</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Grace</u> (Middle) <u>Eagleson</u> (Last) <u>Hause</u>		4. DATE OF DEATH: (Month) <u>4</u> (Day) <u>17</u> (Year) <u>1956</u>	
5. SEX: <u>Fe.</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>2-5-1875</u>
9. AGE last birthday <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDOUSTRY: <u>—</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Andrew T. HARVEY</u>		14. MOTHER'S MAIDEN NAME: <u>Virginia Warner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, (No, or unk.)) (If Yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS: <u>Miss C. N. Eareckson-Robers Ave.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral Vascular accident</u>		<u>36 hrs</u>	
ANTECEDENT CAUSE (B) <u>arteriosclerosis, Hypertension</u>		<u>20 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertensive heart disease</u>		<u>20 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12-28</u> , 19 <u>55</u> , to <u>4-17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-16</u> , 19 <u>56</u> , and that death occurred at <u>8:10 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Sarah Elizabeth Blower</u>		ADDRESS <u>M. D 4208 Anthony St Kensington, Md.</u> DATE SIGNED <u>4-17-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/20/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 14, 1956</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedger</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Dickerson &amp; Sons</u>		ADDRESS <u>Baltimore</u>	

MARGIN RESERVED FOR BINDING





4227

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Purdum</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. # 1 Clarksburg</b>		d. STREET ADDRESS <b>R.F.D. # 1 Clarksburg</b>	
3. NAME OF DECEASED (Type or print) First <b>Darrell</b> Middle <b>R.</b> Last <b>Hawkins</b>		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1956</b>
9. AGE (In years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR <b>2</b> yrs. Hours <b>1</b> Min. <b>5</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Olney, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hamilton Hawkins</b>		14. MOTHER'S MAIDEN NAME <b>Madeline Hebron</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Hamilton Hawkins, Clarksburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Gastro-enteritis (Infectious)?</b> DUE TO * (NOTE: Child seen once only by us and died before it was taken to hospital as arranged.) (b) <b>Was in terminal stage of dehydration from prolonged vomiting and diarrhea, untreated.</b> (c) <b>vomiting and diarrhea, untreated.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>None</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. n.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>soon as emergency once only</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>April 30</b> , 19 <b>56</b> , and that death occurred at <b>5 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Damascus, Maryland</b> DATE WRITTEN <b>4/30/56</b>			
ACTUAL SIGNATURE <b>M. McKendree Boyer</b>		M.D. <b>D. Druid Theatre Building.</b>	
PHYSICIAN'S NAME (Type) <b>M. McKendree Boyer, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 30, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Purdum, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Mobsworth</b>		ADDRESS <b>Damascus, Md.</b>	
24a. REC'D BY REGISTRAR <b>April 30, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Della W. Burdette</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04205

214

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton Hills Sil. Spg.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton Hills Silver Spring, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Luie</b> Middle <b>Lindon</b> Last <b>Hayes</b>		4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1877</b>
9. AGE (In years last birthday) yrs. <b>79</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Elec. Contractor</b>	
11. BIRTHPLACE (State or foreign country) <b>Culpepper Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> (If yes, give year or date of service) <b>1893-1898</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Helen G Hayes</b>		Address <b>3115 Parker St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>acute coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 1/2 hours</b> <b>10 1/2 hrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May</b> , 19 <b>46</b> , to <b>4/25</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/24</b> , 19 <b>55</b> , and that death occurred at <b>2:30</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James T. Burns</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>4/25/56</b>	
PHYSICIAN'S NAME (Type) <b>JAMES T. BURNS M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/28/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>	22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deal Funeral Home</b>		ADDRESS <b>4812 Ga. Ave. N. W.</b>	24a. REC'D. BY REGISTRAR <b>42536</b>
		24b. REGISTRAR'S SIGNATURE <b>Francis R. [Signature]</b>	

RECEIVED

APR 2 1956

BUREAU V. S.

4229

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNM, Bethesda, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>California</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>California</b> d. STREET ADDRESS <b>Bay View Traylor Park</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Willie</b> Middle <b>Mae</b> Last <b>HAYES</b>		4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 17, 1927</b>
9. AGE (In years last birthday) <b>28</b> yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>"D" Frost</b>		14. MOTHER'S MAIDEN NAME <b>Nena A. Perry</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>(Husband) Delbert HAYES, Bay View Traylor Park</b>		Address <b>California, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hodgkin's Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>14 April</b> , 19 <b>56</b> , to <b>15 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>15 April</b> , 19 <b>56</b> , and that death occurred at <b>0725A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 4-16-56</b> ARTIFICIAL SIGNATURE <b>Willard P. Arentzen</b> M.D. PHYSICIAN'S NAME (Type) <b>Willard P. ARENTZEN, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-19-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Henagar Alabama</b>		22d. LOCATION (City, town, or county) (State) <b>Henagar, Alabama</b>	
23. FUNERAL DIRECTOR'S NAME (Type) ADDRESS <b>R.A. PUMPHREY Funeral Home 7557 Wisconsin Ave, Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 4-15-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Harry B. Russell</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The original and a copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
APR 18 1956  
BUREAU V

4230

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Maryland</b>		c. LENGTH OF STAY IN 1b <b>34 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		d. STREET ADDRESS <b>21 Wall Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bradford</b> Middle <b>Nelson</b> Last <b>Headley</b>		4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27, 1888</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>15</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive Assist. (Army)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Army</b>	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Caleb Headley</b>		14. MOTHER'S MAIDEN NAME <b>Carolyn Estes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myeloblastic Leukemia</b> 41 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 9, 1956</b> , to <b>April 12, 1956</b> , that I last saw the deceased alive on <b>April 12, 1956</b> , and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Claude E. Forkner, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Claude E. Forkner, Jr., M. D.</b>		DATE SIGNED <b>4/12/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/14/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		22d. LOCATION (City, town, or county) (State) <b>Beallsville Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 4/14/56</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NNMC, Bethesda, Md.</u>			d. STREET ADDRESS <u>5512 Northfield Road</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Linda</u> Middle <u>Elizabeth</u> Last <u>HINMAN</u>			4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-56</u>	9. AGE (In years last birthday) yrs. <u>1</u> Months <u>1</u> Days <u>16</u> Min.	IF UNDER 1 YEAR Months <u>1</u> Days <u>16</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Albert Harold HINMAN</u>			14. MOTHER'S MAIDEN NAME <u>Caroline Blanks</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>- -</u>		17. INFORMANT Address <u>Father, Albert Harold HINMAN (Same As #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemolytic disease of the newborn</u> DUE TO (b) <u>Rh Incompatibility</u> DUE TO (c) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>6 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>21 April 1956</u> to <u>23 April 1956</u> , that I last saw the deceased alive on <u>23 April 1956</u> , and that death occurred at <u>3:15 A.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Robert L. Baird</u>		ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>4-23-56</u>			
PRINTED NAME (Type) <u>Robert L. Baird, LT, MC, USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-25-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Baird</u>		ADDRESS <u>R.A. Pumphrey Funeral Home, 557 Wisconsin Ave., Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>4-23-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary E. Parnell</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

4232

Reg. Dist. No. 212

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Montgomery</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Montg.</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Boyd, R.F.D.</b>		LENGTH OF STAY (in this place) <b>74 yrs</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Boyd, R.F.D.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Virginia</b> (Middle) <b>B</b> (Last) <b>Hodges</b>				(Month) <b>April</b> (Day) <b>16</b> (Year) <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <b>Widowed</b>	8. DATE OF BIRTH <b>April 3 - 1882</b>	9. AGE last birthday <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Wesley Maxwell</b>				14. MOTHER'S MAIDEN NAME <b>Essie Baker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>William Hodges, Bethesda, Md</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
171X IMMEDIATE CAUSE (A) <b>Carcinoma of the stomach</b>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <b>metastasis to the liver</b>						2 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Anemia</b>						1 year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>7 April 19 53</b> , to <b>16 April 19 56</b> , that I last saw the deceased alive on <b>16 April 19 56</b> , and that death occurred at <b>6:20 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>John J. Lawrence, M.D.</b>		DATE THEREOF <b>4/18/56</b>		NAME OF CEMETERY OR CREMATORY <b>Mt Olivet</b>		LOCATION (City, town, or county) (State) <b>Frederick, Md</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		24. REC'D BY REGISTRAR <b>Charles W. Elgin</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Hilton, Barnesville</b>		ADDRESS <b>P.O. Boyd, Md.</b>	
DATE <b>4/16/56</b>		per <b>W. B. Hilton</b>					

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

APR 22 1964

RECEIVED

4/22/64

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

4159

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>5 mo. 18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsburgh</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium Hospital</u>				d. STREET ADDRESS <u>Ruskin Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Antonia</u> Middle <u>None</u> Last <u>Hoffmann</u>				4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-29-63</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Piano Store</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John m Hoffmann</u>				14. MOTHER'S MAIDEN NAME <u>Helen Simon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>patient's Hospital chart.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angina Pectoris</u> 1420.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-vascular Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremic State</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-11</u> 19 <u>55</u> , to <u>4-29</u> 19 <u>56</u> that I last saw the deceased alive on <u>4-29</u> 19 <u>56</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A Hare</u> M.D.				ADDRESS (Street, city or town, state) <u>Takoma Park, Md</u>		DATE SIGNED <u>4/29/56</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare MD. 809 Davis Ave</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/30/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smithfield Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pittsburgh, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gaudus (son)</u>				ADDRESS <u>1756 Pa. Ave., N.W., D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE 5/1/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>William Redd</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 3 1956

RECEIVED

**4233**

**CERTIFICATE OF DEATH**

04211/4  
Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float:right">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Silver Spring</u> c. LENGTH OF STAY IN 1b <u>10 days</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> <span style="float:right">b. COUNTY <u>Arlington</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Arlington</u>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedarcroft Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>2305 N. 11th St. Apt 304</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Mary</u> Middle <u>Warren</u> Last <u>Horton</u>				<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>6</u> Year <u>1956</u>											
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-12-29</u>		9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>Edgar Warren Taulbee</u>						14. MOTHER'S MAIDEN NAME <u>Mary E. Edwards.</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Charles Horton, 2305 N. 11th St., Arlington.</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pyelonephritis</u> <u>157.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Polycystic Kidneys</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>26 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>nil</u>														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>nil</u>											
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3-27-</u> <u>1956</u> , to <u>4-6-</u> <u>1956</u> , that I last saw the deceased alive on <u>4-5-</u> <u>1956</u> , and that death occurred at <u>4:05 a.m.</u> from the causes and on the date stated above.															
ACTUAL SIGNATURE <u>Arthur Huse</u> M.D.				ADDRESS (Street, city or town, state) <u>Cedarcroft San. &amp; Hospital</u>				DATE SIGNED <u>4-6-56</u>							
PHYSICIAN'S NAME (Type) <u>Dr A. Huse</u>				<u>Route 2, Silver Spring, Md.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-9-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>				22d. LOCATION (City, town, or county) (State) <u>Hyades D.C.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Naylor - 5831 - 29 Ave N.W.</u> ADDRESS						24a. REC'D BY REGISTRAR <u>4/10/56</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any case within 72 hours after death.

8 2 10



4234

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Maryland</b>		c. LENGTH OF STAY IN IB <b>21 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gary</b> Middle <b>Lee</b> Last <b>Howard</b>		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> , Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1947</b>
9. AGE (In years last birthday) <b>8</b> yrs		IF UNDER 1 YEAR: Months <b>8</b> Days <b>30</b> Hours <b>19</b> Min. <b>56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Melvin T. Howard</b>		14. MOTHER'S MAIDEN NAME <b>Betty Maisch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Md., Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2043</b> <b>Route Leukemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>5 mo.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 9, 1956</b> to <b>April 30, 1956</b> that I last saw the deceased alive on <b>April 30, 1956</b> and that death occurred at <b>11:30 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Claude E. Forkner, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>5/4/56</b>	
PHYSICIAN'S NAME (Type) <b>Claude E. Forkner, Jr. M. D.</b>		<b>The National Institutes of Health</b> <b>Bethesda Md., Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 4, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. P. [Signature]</b> ADDRESS <b>Arlington, Virginia</b>		24a. REC'D BY REGISTRAR DATE <b>5/3/56</b>	24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

1956

RECEIVED

4235

## CERTIFICATE OF DEATH

04213

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Maryland</b>		d STREET ADDRESS <b>10127 Pierce Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Ernest</b> Middle <b>Joseph</b> Last <b>HURD</b>		4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 June 1891</b>
9. AGE (In years last birthday) yrs. <b>64</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baker</b>	
11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Joseph JANOWSKI</b>		14. MOTHER'S MAIDEN NAME <b>Anna (Unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW-1 578-05-6606</b>	
17. INFORMANT <b>Violet HURD, (Same As #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the thyroid</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>16 April</b> , 19 <b>56</b> , to <b>26 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>26 April</b> , 19 <b>56</b> , and that death occurred at <b>4:38 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gerald I. Plitman</b>		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Gerald I. PLITMAN, LT, MC, USN</b>		DATE SIGNED <b>4-27-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-30-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Nat'l Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Falls Church, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.E. Pumphrey, 8434 Georgia Ave, SilverSpG.Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 4-27-56</b>	
24b. REGISTRAR'S SIGNATURE <i>Mary E. Carrolly</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
APR 9 • 1956  
BUREAU V. 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the ward "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4236 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04214

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4523 Middleton Lane</b>				d. STREET ADDRESS <b>4523 Middleton Lane</b>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>B</b> Last <b>IRVING</b>				4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 13-1884</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>13</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bu. of Eng. Govt. Retd.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John B. Irving</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Frazer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Allidee Irving Sister</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> DUE TO <b>199.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of face, throat &amp; neck</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>Found dead in bed 1 yr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschant</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>FRANK J. Broschant</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>4-26-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-28-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>4-28-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

U.S. AIR FORCE

MAY 1 1951

RECEIVED  
MAY 1 1951

4237

CERTIFICATE OF DEATH

Reg. Dist. No.

04215

216

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5910 Springfield Drive</b>				d. STREET ADDRESS <b>5910 Springfield Drive</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>M.</b> Last <b>JACKSON</b>		4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>1956</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-4-64</b>	9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months <b>4</b> Days <b>8</b> Hours <b></b> Min <b></b>	IF UNDER 24 HRS. Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Frey</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Crumbling</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT <b>Mrs L. H. Kimmel-Item# 2</b>			
				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>450.0</b> IMMEDIATE CAUSE (a) <b>Pulmonary Congestion - Respiratory Failure</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arterio sclerosis Generalized</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>6 yrs</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 1949</b> , 19____, to <b>4/12/56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/12</b> , 19 <b>56</b> , and that death occurred at <b>9:25 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Sherman A. Thomas</b>		M.D. <b>4301 48th St. N.W. Wash. D.C.</b>		ADDRESS (Street, city or town, state) <b>4301 - 48th St., N.W.</b>		DATE SIGNED <b>4/12/56</b>	
PHYSICIAN'S NAME (Type) <b>Sherman A. Thomas</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-16-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Rose</b>		22d. LOCATION (City, town, or county) (State) <b>York, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>				ADDRESS <b></b>		24a. REC'D BY REGISTRAR <b>DATE 4/14/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04216

## 4238 CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Olney</u>		<u>8 days</u>		TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County General, Hosp, Inc</u>				STREET ADDRESS (If rural give location) <u>Route 1, Bonifant Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Frederick</u> (Middle) <u>W.</u> (Last) <u>Jenkins, Sr.</u>				(Month) <u>April</u> (Day) <u>26</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>4/21/90</u>	<u>66</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>PLUMBER</u>		<u>WASH. GAS CO.</u>		<u>District of Columbia</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Cyprain Jenkins</u>				<u>Catherine Ulrich</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>(If Yes, give war or dates of service)</u>		<u>577-07-7740 A</u>			
				<u>Hospital Record</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>L</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>L</u>		<u>L</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>7/1/56</u> , to <u>4/26/56</u> , that I last saw the deceased alive on <u>4/26/56</u> , and that death occurred at <u>10:20 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. M. Bird</u> (J. M. BIRD)				ADDRESS (Street, city, town, state) <u>Sandy Spring, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>BURIAL</u>		<u>4/30/56</u>		<u>CEDAR HILL CEMETERY</u>		<u>PRINCE GEO. CO., MARYLAND</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>4-28-56</u>		<u>Gertrude B. Lawler</u>		<u>Walter B. Humphrey</u>		<u>SILVER SPRING, MD.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

MAY 3 1956

RECEIVED

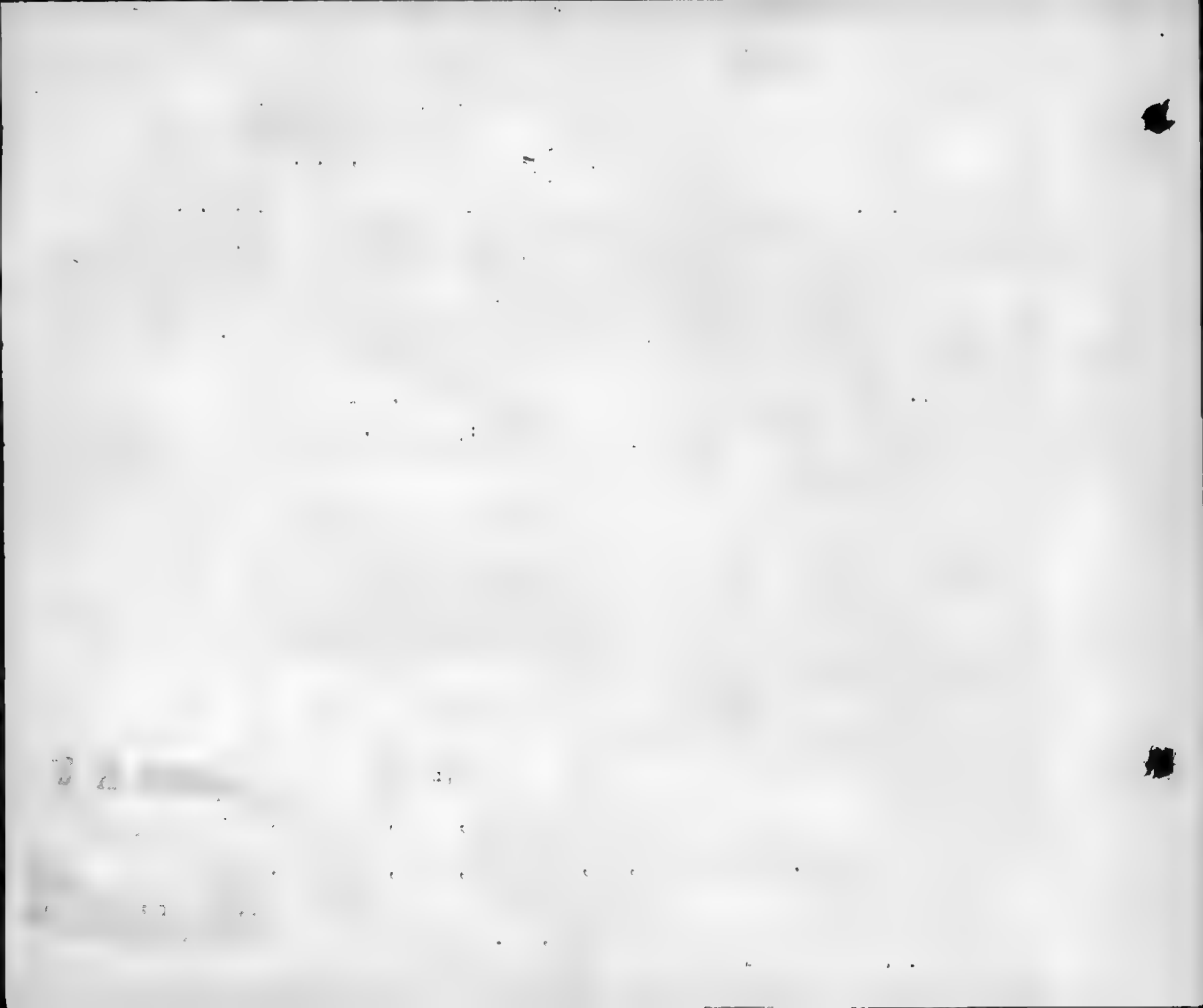
4239

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> <b>D.C. COUNTY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Rural</b>		c. LENGTH OF STAY IN 1b <b>2 mo 2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lula</b> Middle <b>Mae</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-3-15</b>
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Tildon V. HORN</b>		14. MOTHER'S MAIDEN NAME <b>Harriet V. HORN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Husband: John F. JONES MMC USN</b> <b>Same as item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leukemia, Acute</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>7 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7 Feb</b> , 19 <b>56</b> , to <b>9 Apr</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9 Apr</b> , 19 <b>56</b> , and that death occurred at <b>7:20A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Willard P. Arentzen</b> M.D.		ADDRESS (Street, city or town, state) <b>USNH, NNMC, Bethesda, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Willard P. ARENTZEN CDR, MC, USN</b>		DATE SIGNED <b>4-9-56</b>	
22b. DATE THEREOF <b>4-11-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lafayette Memorial</b>	
22d. LOCATION (City, town, or county) <b>Fayetteville, North Carolina</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. PUMPHREY</b> ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>4-9-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Harry E. ...</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4240

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>18 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Joseph</b> Last <b>KAPPRAL</b>		4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2 April 1956</b>
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min <b>18</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>	
11. BIRTHPLACE (State or foreign country) <b>Bethesda, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Thomas George KAPPRAL</b>		14. MOTHER'S MAIDEN NAME <b>Christiana A. HARKINS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Thomas G. KAPPRAL Father, 641 Notabene St.</b>		Address <b>Alexandria, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO <b>Septicemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Primaturity</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>10 hours</b> <b>10 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-2-56</b> , 19 <b>56</b> , to <b>4-3-</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3 April</b> , 19 <b>56</b> , and that death occurred at <b>12:25A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>J. W. STOHLMAN, LT, MC, USN</b>		PHYSICIAN'S NAME (Type) <b>U. S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-5-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b> <b>7557 Wisconsin Ave.,</b>	
24a. REC'D BY REGISTRAR <b>4-3-56</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Russell</b>	

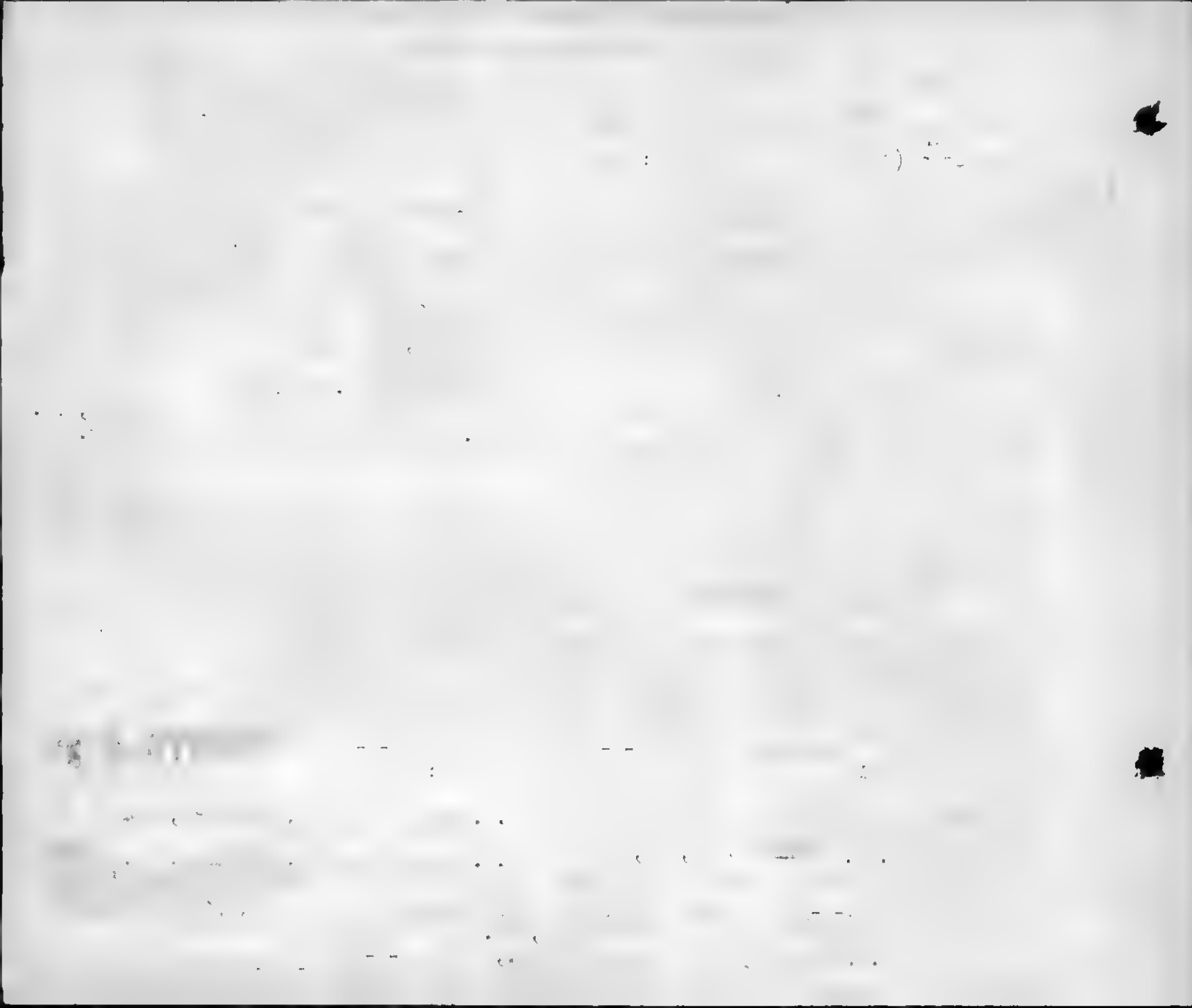
MEDICAL CERTIFICATION

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4160

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND		STATE <u>MD.</u> COUNTY <u>Montgomery</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>		STREET ADDRESS (If rural, give location) <u>751 Silver Spring Ave.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Takoma Park</u>		LENGTH OF STAY (in this place) <u>4 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>		STREET ADDRESS (If rural, give location) <u>751 Silver Spring Ave.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7300 Baltimore Ave.</u>							
3. NAME OF DECEASED: (First) <u>EDITH</u> (Middle) <u>KARR</u> (Last) <u>KARR</u>				4. DATE OF DEATH: (Month) <u>2</u> (Day) <u>13</u> (Year) <u>1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>10/19/1873</u>	
9. AGE last birthday: <u>82</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles D. Spencer</u>				14. MOTHER'S MAIDEN NAME: <u>Louisa Ingraham</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>				16. SOCIAL SECURITY No.: <u>None</u>			
17. INFORMANT & ADDRESS: <u>Mrs. E.A. Powell 751 Silver Spring Ave. S.S. Md.</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Bronchopneumonia</u>						<u>2 days</u>	
DUE TO Antecedent cause(s) (b) <u>Inanition</u>						<u>3 yrs.</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Parkinson's Disease</u>						<u>7 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized Arteriosclerosis</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/11</u> , 19 <u>56</u> , to <u>4/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/12</u> , 19 <u>56</u> , and that death occurred at <u>12:01 p.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edmund L. Burnett</u> (DEGREE OR TITLE) ADDRESS <u>M.D. 7701 Carroll Ave. Takoma Park, Md</u>				DATE SIGNED <u>4/13/56</u>			
23. BURIAL, CREMATION REMOVAL (Specify): <u>Cremation</u>		DATE THEREOF <u>4/16/56</u>		NAME OF CEMETERY OR CREMATORY: <u>Fort Lincoln Cemetery Prince George Co.</u>		LOCATION (City, town, or county) (State) <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>4/14/56</u>		REGISTRAR'S SIGNATURE <u>J. Milton Dadd</u>		24. FUNERAL DIRECTOR <u>Wm. L. Jones Co.</u>		ADDRESS <u>2901-14 St. 14th Ave.</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

APR 17 1950

RECEIVED



4241

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oiney</b>				c. LENGTH OF STAY IN 1b <b>14 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>				d. STREET ADDRESS <b>5707 38th street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Alexander</b> Last <b>Kennedy</b>				4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/5/79</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>6</b> Hours <b>16</b> Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. MAIL CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. GOV'T.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David Alexander Kennedy</b>				14. MOTHER'S MAIDEN NAME <b>Mary Virginia Fox</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Hospital Record</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>15 hrs.</b> <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 15, 1956</b> , to <b>April 16, 1956</b> , that I last saw the deceased alive on <b>April 16, 1956</b> , and that death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. D. Bonifant</b> M.D.				DATE SIGNED <b>4/16/56</b>			
PHYSICIAN'S NAME (Type) <b>A. D. Bonifant, M. D.</b>				<b>SANDY SPRING, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/19/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GLENWOOD CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner G. Humphrey</b> ADDRESS <b>SILVER SPRING, MD.</b>				24a. REC'D BY REGISTRAR <b>DATE 4-18-56</b>		24b. REGISTRAR'S SIGNATURE <b>Gertrude B Lawler</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED V. S.

APR 1957

RECEIVED V. S.

4242

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>3 mos 14 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>562 Portland St., S.E.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PLACIDE</b> Middle <b>THOMPSON</b> Last <b>KERRICK</b>		4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-15-86</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Oscar THOMPSON</b>		14. MOTHER'S MAIDEN NAME <b>Lucia REDDING</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>(Daughter) Mrs. Placide Smyth, South Glen Road.,</b>		Address <b>Rockville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, Ovaries with metastases</b> <b>115x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Nephritis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2-4 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 28, 1955</b> , to <b>12 April, 1956</b> , that I last saw the deceased alive on <b>12 April, 1956</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. V. Caligiri</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 4-12-56</b>	
PHYSICIAN'S NAME (Type) <b>J. V. CALIGIRI, LSPR, MC, USNR</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-16-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill, West</b>	22d. LOCATION (City, town, or county) (State) <b>Philadelphia, Penna.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor &amp; Sons</b>		24a. REC'D BY REGISTRAR <b>4-12-56</b>	
ADDRESS <b>John M. Taylor &amp; Sons, Annapolis, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Doreally</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAR V. 8

APR 16 1950

REAR V. 8

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the executor of the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. AISME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4243 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04222  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville - city 13</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville - city 13</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sycamore Acres</u>				d. STREET ADDRESS <u>Sycamore Acres</u>			
3. NAME OF DECEASED (Type or print) First <u>Vernon</u> Middle <u>Dorman</u> Last <u>King Sr.</u>				4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-42</u>	9. AGE (in years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bricklayer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lawrence King</u>				14. MOTHER'S M maiden NAME <u>Mabel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>21X-18-8569</u>		17. INFORMANT <u>Elvira King (wife)</u> Address <u>same as dec'd</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/11/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter C. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>4/11/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Laurel H. Hagler</u>		DATE SIGNED <u>4-8-56</u>	

W. A. LUCAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4161

## CERTIFICATE OF DEATH

04223

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md</u>	
c. LENGTH OF STAY IN 1b <u>68 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp.</u>		d. STREET ADDRESS <u>4201 Van Buren St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lillian</u> First <u>Thelma V. Kushner</u> Middle <u>Thelma V. Kushner</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-92</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harris Venezky</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Domish</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wash. San + Hosp Records - Son.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforation of Stomach - Peritonitis</u> 196X DUE TO <u>irradiation effect for</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Giant Cell Sarcoma of Vertebra</u> DUE TO <u>Primary in left femur</u> (c) <u>Healed Rheumatic Carditis - Carcinoma of Uterus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1 year</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/13</u> , 19 <u>47</u> , to <u>4/30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/30</u> , 19 <u>56</u> , and that death occurred at <u>1:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cecile L. Fusfeld M.D.</u>		DATE SIGNED <u>4/30/56</u>	
PHYSICIAN'S NAME (Type) <u>Cecile L. Fusfeld M.D.</u>		ADDRESS (Street, city or town, state) <u>2026 R-St. N.W. Wash DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>5/1/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Capt. Helen C.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Blumenthal</u>		ADDRESS <u>3501-14th St NW</u>	
24a. REC'D BY REGISTRAR <u>3/2/56</u>		24b. REGISTRAR'S SIGNATURE <u>John W. ...</u>	

BUREAU V. S.

MAY 3 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4162 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04224

Reg. Dist. No. 223

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN life <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>54 Walnut AVE.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>54 Walnut AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Eugene</u> Middle <u>Ray</u> Last <u>Lane</u>			<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>1</u> Year <u>1958</u>				
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1/2/07</u>	<b>9. AGE</b> (In years last birthday) <u>50</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>plumber-contractor</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>GLN PLUMBING</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>TOPEKA, KANSAS</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>WILLIAM R. LANE</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>GERTRUDE FARMAN</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>YES</u>		<b>16. SOCIAL SECURITY NO.</b> (If not, give reason: dates of service) <u>WW II</u>		<b>17. INFORMANT</b> Address <u>WASH. DC.</u> <u>MRS. SADIE L. WARD - 714 QUICKEN BOX ST. NW</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>2001</u> DUE TO <u>Carbon monoxide poisoning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in auto</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>hose attached from exhaust to window of car</u>					
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a. m. <u>  </u> p. m. <u>4/1/58</u>	<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>home</u>		<b>20f. (City or town)</b> <u>Takoma Pk.</u>	<b>(County)</b> <u>Montg.</u>	<b>(State)</b> <u>Md.</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> M.D.			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>EXAMINER'S NAME (Type)</b> <u>Frank J. Broschart</u>			<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			<b>DATE SIGNED</b> <u>4/1/58</u>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>APRIL 4, 1958</u>		<b>22b. DATE THEREOF</b> <u>APRIL 4, 1958</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>ARLINGTON NATL CEM.</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>ARLINGTON</u>		<b>(State)</b> <u>VA.</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John S. Hall</u>			<b>24a. REC'D BY REGISTRAR</b> <u>4-3-58</u>				
<b>24b. REGISTRAR'S SIGNATURE</b> <u>John S. Hall</u>			<b>24c. REGISTRAR'S SIGNATURE</b> <u>John S. Hall</u>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the examiner should be notified by the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

W. A. RUTLEDGE

W. A. RUTLEDGE

W. A. RUTLEDGE

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W. A. RUTLEDGE

4244

## CERTIFICATE OF DEATH

04225

Reg. Dist. No. 217

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Claney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery Co Cent Hosp Inc.</u>		d. STREET ADDRESS <u>12001 Colesville Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Charles S. LAWRENSON</u>		4. DATE OF DEATH <u>April 8</u> 19 <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 30 - 1896</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REPRESENTATIVE OF REAL ESTATE COMMISSION</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STATE OF MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARVEY M. LAWRENSON</u>		14. MOTHER'S MAIDEN NAME <u>JULIA E. KING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>#1 and #2</u>		16. SOCIAL SECURITY NO. <u>XXXXXXXXXXXX</u>	
17. INFORMANT <u>MRS. BERNICE M. LAWRENSON, 12,001 Colesville Rd.</u>		Address <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic degenerative</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 8, 1956</u> to <u>April 8, 1956</u> , that I last saw the deceased alive on <u>April 8, 1956</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. D. Bonifant</u>		ADDRESS (Street, city or town, state) <u>Sandy Spring, Md</u> DATE SIGNED <u>4/8/56</u>	
PHYSICIAN'S NAME (Type) <u>A. D. BONIFANT</u>		<u>SANDY SPRING, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/11/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, SILVER SPRING, MARYLAND</u>		24a. REC'D BY REGISTRAR <u>DATE 4-10-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bernice M. Lawrenson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4245

## CERTIFICATE OF DEATH

04226

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Maryland</b>	
c. LENGTH OF STAY IN 1b <b>1 day</b>		d. STREET ADDRESS <b>3 Pooks Hill Road, Apt 704</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center National Institutes of Health</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Stewart</b> Last <b>LeClaire</b>		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 6, 1891</b>
9. AGE (In years last birthday) yrs. <b>65</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- -</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Eaton</b>		14. MOTHER'S MAIDEN NAME <b>Nelissa Uhls</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>The medical record The Clinical Center</b>		Address <b>Nat'l Inst. of Health Bethesda, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic Cancer</b> 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Breast Carcinoma</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Electrolyte Imbalance</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 9, 1956</b> , to <b>April 10, 1956</b> , that I last saw the deceased alive on <b>April 10, 1956</b> , and that death occurred at <b>5:55 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arnold Flick, M.D.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center National Institutes of Health Bethesda, Md.</b>	
DATE SIGNED <b>4/11/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 4-12-56</b>		22b. DATE THEREOF <b>4-12-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Abbey</b>		22d. LOCATION (City, town, or county) (State) <b>Portland, Oregon</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>4/14/56</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

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APR 1 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4246

## CERTIFICATE OF DEATH

0422216  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
c. LENGTH OF STAY in 1b <u>3 days</u>				d. STREET ADDRESS <u>3501 Shepherd St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert Crockett</u> First <u>Lester</u> Middle <u>Lester</u> Last				4. DATE OF DEATH <u>April</u> Month <u>10</u> Day <u>1956</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 9, 1881</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>10</u> Min.		IF UNDER 24 HRS. Months <u>7</u> Days <u>10</u> Hours <u>10</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor Organizer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery &amp; Sales</u>		11. BIRTHPLACE (State or foreign country) <u>Bethesda, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Crockett Lester</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Gingell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Wife. Mary H. Lester - same as above</u>			
17. INFORMANT <u>Wife. Mary H. Lester - same as above</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>154X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of rectosigmoid Colon</u> DUE TO <u>2 years</u> (c) <u>7</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Suppuration Rt</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October, 1954</u> to <u>April 10, 1956</u> that I last saw the deceased alive on <u>April 9, 1956</u> , and that death occurred at <u>125 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney C. Cousing</u> M.D. <u>3921. Briggsman St. NW</u> <u>4/11/56</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>SIDNEY C. COUSING</u>				<u>Wash. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-13-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>4/14/56</u>		24b. REGISTRAR'S SIGNATURE <u>Basile Thompson</u> <u>Reg. Dir.</u>	

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4247

## CERTIFICATE OF DEATH

Reg. Dist. 04228

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>10 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Elizabeth</u> Last <u>Lethbridge</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/10/74</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Owen Disney</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Hospital Record</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.1</u> IMMEDIATE CAUSE (a) <u>Myocarditis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>11</u> years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis Multiple</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/1/1952</u> to <u>4/4/1956</u> , that I last saw the deceased alive on <u>4/4/1956</u> , and that death occurred at <u>8:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. W. Bird</u>		DATE SIGNED <u>4/7/56</u>	
PHYSICIAN'S NAME (Type) <u>J. W. Bird, M. D.</u>		ADDRESS (Street, city or town, state) <u>Sandy Spring</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>APRIL 7 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BURTONSVILLE</u>	22d. LOCATION (City, town, or county) (State) <u>HOWAR CO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u>		24a. REC'D BY REGISTRAR <u>  </u>	24b. REGISTRAR'S SIGNATURE <u>Bertina B. Lawler</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 10 1956

UNITED STATES

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04229

4163

## CERTIFICATE OF DEATH

Reg. Dist. No.

173

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	c. LENGTH OF STAY IN 1b <u>2 1/2 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Gen. Hospital</u>		d. STREET ADDRESS <u>2616 Lamont St. N.W.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Julius</u> Middle <u>NO</u> Last <u>Liff</u>	4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1956</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Russia</u>
13. FATHER'S NAME <u>Isaac Liff</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Hospital Records</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Bladder Neck Obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Prostatic Hypertrophy</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, Generalized</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Apr. 10., 1956</u> , to <u>April 24, 1956</u> , that I last saw the deceased alive on <u>April 24, 1956</u> , and that death occurred at <u>11:26 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur S. Bresler</u>		M.D. <u>533 Riggs Rd, N.E.</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>4-24-56</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR S. BRESLER</u>		<u>Washington, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment</u>	22b. DATE THEREOF <u>4/26/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elihu</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sammaneky</u> ADDRESS <u>3501-14th St</u>		24a. REC'D BY REGISTRAR DATE <u>4-27-56</u>	24b. REGISTRAR'S SIGNATURE <u>J. H. Dody</u>

RECEIVED

APR 1 1956

BUREAU V. S.

4164

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>—</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>5 mos - 5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Sumner</u> Last <u>Lobingier</u>		4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-30-1866</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Judge</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
12. BIRTHPLACE (State or foreign country) <u>Illinois</u>		13. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
14. FATHER'S NAME <u>George Lobingier</u>		15. MOTHER'S MAIDEN NAME <u>Ada Stewart</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <u>Hosp. Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>180X</u> DUE TO <u>uremia</u> (b) <u>Carcinoma of kidney</u> DUE TO <u>—</u> (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>1 year?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure - Generalized arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 22</u> , 19 <u>55</u> to <u>April 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 27</u> , 19 <u>56</u> , and that death occurred at <u>1:42 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. W. Whitlock</u>		ADDRESS (Street, city or town, state) <u>Washington San + Hosp. Takoma Park, Md</u>	
PHYSICIAN'S NAME (Type) <u>J. W. Whitlock</u>		DATE SIGNED <u>4/29/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/30/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Washington Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion W. Hyman</u>		ADDRESS <u>1300 N St NW</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>J. Whitlock</u>	
DATE <u>4/29/56</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EDWARD R. S.

AY

1700 N. 1st St. N. W.  
N. 1st St. N. W.

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4248

## CERTIFICATE OF DEATH

04231

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Bethesda</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD # 3 Bethesda</b>		d. STREET ADDRESS <b>RFD # 3 Bethesda</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES MACKIN LYNCH</b>		4. DATE OF DEATH Month Day Year <b>April 18, 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-9-89</b>
9. AGE (In years last birthday) yrs <b>66</b>		10. IF UNDER 1 YEAR Months Day Hours Min. <b>4 9</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <b>Never Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Lynch</b>		14. MOTHER'S MAIDEN NAME <b>Lucinder Roberta Conley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT Address <b>Paul Conley-Item # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Acute Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Cardiac Decompensation</b> (c) DUE TO <b>Advanced Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>2 months</b> <b>6 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/10, 1956</b> to <b>4/18, 1956</b> , that I last saw the deceased alive on <b>4/17, 1956</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank Jagers</b>		ADDRESS (Street, city or town, state) <b>5707 Wisconsin Ave</b>	
PHYSICIAN'S NAME (Type) <b>FRANK JAGGERS</b>		DATE SIGNED <b>4/18/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-20-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Gabriels</b>		22d. LOCATION (City, town, or county) (State) <b>Potomac, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>4/21/56</b>	
		24b. REGISTRAR'S SIGNATURE <b>Bennie M. Shonfranc</b>	

JOHN W. B.

APR 27 1961

RECEIVED



4249

## CERTIFICATE OF DEATH

04232

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Montg. Co. Gen. Hosp.</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Olney</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>208 Monroe Street ROCKVILLE</b>	
d. STREET ADDRESS <b>208 Monroe Street</b>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ada</b> Middle <b>Stella</b> Last <b>MARTH</b>		4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1886</b>
9. AGE (In years last birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>2</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Montg. Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Franklin Carter</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Bolton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>William G. Marth-Same Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis (Rt. Fig. Tr.)</b> DUE TO (c) <b>Diabetes</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial - Cerebral Vascular accident - 3 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 19</b> , <b>19 56</b> , to <b>Apr. 5</b> , <b>19 56</b> , that I last saw the deceased alive on <b>April 4</b> , <b>19 56</b> , and that death occurred at <b>1:30 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.		ADDRESS (Street, city or town, state) <b>Garthman ml.</b> DATE SIGNED <b>4/5/56</b>	
PHYSICIAN'S NAME (Type) <b>Frank J. Broschart, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/9/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Union</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda</b>		24a. REC'D BY REGISTRAR <b>DATE 4-7-56</b>	
		24b. REGISTRAR'S SIGNATURE <b>Gertrude B. Lawler</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04233

4250

## CERTIFICATE OF DEATH

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN IB <b>20 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
3. NAME OF DECEASED (Type or print) First <b>Lumanda</b> Middle <b>(no middle name)</b> Last <b>Massey</b>		4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1917</b>
9. AGE (In years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR Months <b>38</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Massey</b>		14. MOTHER'S MAIDEN NAME <b>Lula Dickerson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>not available</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Autostatic carcinoma of breast</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 15, 1956</b> , to <b>April 4, 1956</b> , that I last saw the deceased alive on <b>April 4, 1956</b> and that death occurred at <b>12:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur G. Ship</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/5/56</b>	
PHYSICIAN'S NAME (Type) <b>Arthur G. Ship, M. D.</b>		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-9-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>	22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Rhines &amp; Co.</b>		ADDRESS <b>901 3rd St. S.W.</b>	
24a. REC'D BY REGISTRAR <b>Mary C. Fennelly</b>		24b. REGISTRAR'S SIGNATURE <b>Mary C. Fennelly</b>	

BUREAU V. S.

APR 10 1956

RECEIVED

4251

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Columbia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital</u>		d. STREET ADDRESS <u>1219 Michigan Avenue, N.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Margaret</u> Last <u>MAURER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-9-90</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u> IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Michael FREBERT</u>		14. MOTHER'S MAIDEN NAME <u>Catherine VOIT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Unknown</u>	
17. INFORMANT <u>Husband Mr. Gustav MAURER</u> <u>Same as item #2</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Stomach</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>
20f. (City or town) <u>  </u>		(County) <u>  </u> (State) <u>  </u>	
21. I certify that I attended the deceased from <u>13 March</u> , 19 <u>56</u> , to <u>15 April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>15 April</u> , 19 <u>56</u> , and that death occurred at <u>1:00P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.H. Howell</u>		DATE SIGNED <u>4-16-56</u>	
PHYSICIAN'S NAME (Type) <u>W.H. HOWELL, LCDR, MC, USN</u>		<u>USNH, NNJC, Bethesda, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>13 Apr 56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cemetery</u>
22d. LOCATION (City, town, or county) <u>Washington, D.C.</u>		(State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. This Co.</u>		ADDRESS <u>Hines Funeral Home</u> <u>2201 14th Street, Wash D.C.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEAN V. B.

APR 18 1956

RECEIVED

## 4252 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				d. STREET ADDRESS <b>813 Juniper St. N. W.</b>			
3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle <b>Plato</b> Last <b>McGarrick</b>				4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/23/82</b>		9. AGE (In years last birthday) yrs <b>73</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't.</b>		11. BIRTHPLACE (State or foreign country) <b>Pittsburg, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Harvey</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>YES</b>		17. INFORMANT <b>Fdna Plato, daughter, 813 Juniper St., N.W.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>260X</b> (b) <b>Arteriosclerosis</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1944</b> to <b>4 April, 1956</b> that I last saw the deceased alive on <b>4 April, 1956</b> , and that death occurred at <b>6:10 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William D. Aud</b>				ADDRESS (Street, city or town, state) <b>9006 Colesville Rd., Silver Spring, Md.</b>			
PHYSICIAN'S NAME (Type) <b>WILLIAM D. AUD</b>				DATE SIGNED <b>4/7/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/6/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner B. Humphrey</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>DATE 4/7/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1010



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed by the medical examiner or the funeral director. Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

425 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04236  
Reg. Dist. No. 276

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase,</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4208 Leland Street</b>				d. STREET ADDRESS <b>4208 Leland Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JANIE SMITH McCORKLE</b>				4. DATE OF DEATH Month Day Year <b>April 30, 19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>June 23, 1877</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR <b>10</b> Months <b>10</b> Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Smith</b>				14. MOTHER'S MAIDEN NAME <b>Hannah Marshall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>Arthur Wood-Item # 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>400.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month, Day, Year <b>19 56</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>4-30-56</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-2-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Lynchburg, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>				ADDRESS <b>4/30/56</b>		24b. REGISTRAR'S SIGNATURE <b>Bernie M. Thompson</b>	

RECEIVED

MAY 2 1956

BUREAU V. S.

4254

## CERTIFICATE OF DEATH

04237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>West Virginia</b>		b. COUNTY <b>- -</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>20 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beckley</b>		<b>0674</b>	
3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, National Institutes of Health</b>				d. STREET ADDRESS <b>201 Woodlawn Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Dorothy</b>		First <b>Viola</b>		Middle <b>McCullough</b>		Last <b>April 17, 1956</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 27, 1914</b>	
9. AGE (In years last birthday) yrs. <b>42</b>		IF UNDER 1 YEAR Months <b>12</b>		IF UNDER 24 HRS. Days <b>12</b>		Hours <b>12</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Circulation Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Howard McCullough</b>				14. MOTHER'S MAIDEN NAME <b>Elsie Long</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>234-10-7063</b>		17. INFORMANT <b>The medical record</b>			
				Address <b>Nat'l Inst of Health Bethesda, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410X Multiple pulmonary infections - found at autopsy</b> DUE TO (b) <b>Post operative mitral &amp; Aortic Commissurotomy</b> DUE TO (c) <b>Traumatic Heart Disease, Mitral &amp; Aortic Stenosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. INTERVAL BETWEEN ONSET AND DEATH <b>Instantaneously</b> <b>6 days</b> <b>37 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 28, 1956</b> , to <b>April 17, 1956</b> , that I last saw the deceased alive on <b>April 17, 1956</b> , and that death occurred at <b>6:15/2 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/18/56</b> ACTUAL SIGNATURE <b>Edward H. Sharp</b> M.D. <b>National Institutes of Health</b> <b>Bethesda, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>4-18-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Beckley, W. Va.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE 4-18-56</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 20 1900

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4255

## CERTIFICATE OF DEATH

04238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>Rockville</u>			
3. NAME OF DECEASED (Type or print) <u>Kim</u> First <u>Lizabeth</u> Middle <u>BABY GIRL</u> Last <u>McFARLAND</u>				4. DATE OF DEATH <u>4</u> Month <u>7</u> Day <u>1956</u> Year			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4 Apr 56</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Non-applic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Non-applic</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>STANLEY J. JR</u>				14. MOTHER'S MAIDEN NAME <u>NANCY W. WRIGHT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MOTHER</u> Address <u>1906 ROCKLAND AVE ROCKVILLE, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sustained Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Subdural hemorrhage + rt. Adrenal</u> DUE TO (c) <u>Birth Trauma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>4 Apr 1956</u> to <u>7 Apr 1956</u> , that I last saw the deceased alive on <u>6 Apr 1956</u> , and that death occurred at <u>6:30 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>809 VIERS MILL RD, ROCKVILLE</u> DATE SIGNED <u>Francis J Troendle</u> ACTUAL SIGNATURE <u>Francis J Troendle</u> M.D. <u>FRANCIS J TROENDLE MD</u> PHYSICIAN'S NAME (Type) <u>FRANCIS J TROENDLE MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Apr 9 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Rockville</u>				(State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Lamoreaux</u> ADDRESS <u>4510 Liberty Heights Ave Baltimore</u>				24a. REC'D BY REGISTRAR <u>Beccie Thompson</u>		24b. REGISTRAR'S SIGNATURE <u>Beccie Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 215

4256

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN 1b <b>3 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>			d. STREET ADDRESS <b>RR-2 Box-9</b>		
3. NAME OF DECEASED (Type or print) First <b>Randolph</b> Middle <b>WYATT</b> Last <b>MC LAINE</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>13</b> Year <b>1956</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-19-54</b>		9. AGE (In years last birthday) yrs. <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>Washington State</b>	
13. FATHER'S NAME <b>Calvin MC LAINE</b>			14. MOTHER'S MAIDEN NAME <b>Clara GOFF</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(Father) Calvin MC LAINE</b> Address <b>RR-2 Box-9 Waldorf, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b> DUE TO <b>Cardiac Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congenital Heart Disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>24 hrs</b> <b>19 mos</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>10 April</b> , 19 <b>56</b> , to <b>13 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>13 April</b> , 19 <b>56</b> , and that death occurred at <b>10:50A</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>J. W. Peabody, Jr.</b>		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b>		DATE SIGNED <b>4-13-56</b>	
PHYSICIAN'S NAME (Type) <b>J.W. PEABODY, Jr. LT, MC, USN</b>		U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-16-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Arlington</b>		22e. (State) <b>Virginia</b>		22f. (Country)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. PUMPHREY</b>		ADDRESS <b>7557 Wisc. Ave., Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>4-13-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Barry E. Casselley</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 1

BUREAU V. S.



4165

CERTIFICATE OF DEATH

04240

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7 Hickory Ave</u>		d. STREET ADDRESS <u>7 Hickory Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Campbell</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 19 1897</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumber</u>	
11. BIRTHPLACE (State or foreign country) <u>Galesburg, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John D. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Jemima Campbell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-01-7992</u>	
17. INFORMANT <u>Lois Miller</u>		Address <u>7 Hickory Ave, Takoma Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinoid</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Origin in Cecum</u> DUE TO (c) <u>Enteritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Mar. 1955</u> <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/24</u> 19 <u>53</u> , to <u>3/26</u> 19 <u>56</u> , that I last saw the deceased alive on <u>3/26</u> 19 <u>56</u> , and that death occurred at <u>10</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard T Morse</u>		ADDRESS (Street, city or town, state) <u>7030 Carroll Ave Takoma Park, Md</u>	
PHYSICIAN'S NAME (Type) <u>Howard T Morse</u>		DATE SIGNED <u>4/5/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Apr. 7, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASH'N. CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>RIGGS RD. ARLINGTON, VA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Stalder</u>		24a. REC'D BY REGISTRAR <u>John Dodd</u>	
ADDRESS <u>254 CARROLL ST. NW WASH DC</u>		DATE <u>4/6/56</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EDWARD A. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4257 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04241

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4622 Bayard Blvd</u>				d. STREET ADDRESS <u>4622 Bayard Blvd</u>			
3. NAME OF DECEASED (Type or print) <u>Valerie Agnes Miller</u>				DATE OF DEATH <u>July 31</u> 19 <u>56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14 1892</u>	9. AGE (In years last birthday) <u>63</u> Yr.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec. relvnt Wash. State</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NY</u>		11. BIRTHPLACE (State or foreign country) <u>NY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry V. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Ida Kerber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes, give war or dates of service</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>John V. Miller (brother) Same as Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u></u>	(County) <u></u>	(State) <u></u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Bioschait</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-29-56</u>			
EXAMINER'S NAME (Type) <u>FRANK J. BIOSCHAIT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY 2, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>	22d. LOCATION (City, town, or county) <u>WASHINGTON, D.C.</u>	(State) <u></u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVol</u>		ADDRESS <u>2224 Wis Ave</u>		24a. REC'D BY REGISTRAR <u>5-1-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		

MEDICAL CERTIFICATION

BUREAU V. S.

MAY 8 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04242

4258

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> <b>COUNTY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN TB <b>2mo.23 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Jane</b> Last <b>MONROE</b>		4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8 June 1901</b>
9. AGE (In years last birthday) <b>54 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gov't Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>	
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Mary Gardner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>(Friend) Mr. E. Eugene LUTHER</b>		Address <b>Arlington, Va. 1424 N. Uhle St.,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Colon with widespread Metastases</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (d) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2 Feb.</b> , 19 <b>56</b> , to <b>25 Apr.</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>25 April</b> , 19 <b>56</b> , and that death occurred at <b>1:30 P. M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frederick W. Meyer, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>4-26-56</b>	
PHYSICIAN'S NAME (Type) <b>Frederick W. Meyer, Jr.</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-28-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. Hines</b> ADDRESS <b>2901 14th St. N.W. Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE 4-25-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary E. Gosselly</b>			

RECEIVED

1950

BUREAU V. S.

## 4259 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Montgomery</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Bethesda</i>	LENGTH OF STAY (in this place) <i>13 Mo.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Chevy Chase</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Resnor Sanatorium</i>		STREET ADDRESS (If rural give location) <i>142. Mapton St.</i>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <i>Grace</i>	(Middle) <i>A.</i>	(Last) <i>Mullikin</i>	<i>April 28 1956</i>
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>widow</i>	8. DATE OF BIRTH: <i>March 20, 1865</i>
9. AGE last birthday: <i>91</i> yrs.		10. IF UNDER 1 YEAR: Months <i>1</i> Days <i>8</i> Hours <i></i> Min. <i></i>	
11. BIRTHPLACE (State or foreign country): <i>March 28, 1865</i>		12. CITIZEN OF WHAT COUNTRY: <i>USA</i>	
13. FATHER'S NAME: <i>George McNeal</i>		14. MOTHER'S MAIDEN NAME: <i>Susan J. McNeal</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>no</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <i>None</i>	
17. INFORMANT'S ADDRESS: <i>Deceased</i>			
15. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE <i>Congestive Failure &amp; Pericardial Failure</i>			
(B) ANTECEDENT CAUSE (S) <i>Arteriosclerotic Heart Disease</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>August, 1955</i> , to <i>April, 1956</i> , that I last saw the deceased alive on <i>April 28, 1956</i> , and that death occurred at <i>5:55 P.M.</i> , from the causes and on the date stated above.			
SIGNATURE <i>Donald C. Ekman</i>		DATE SIGNED <i>April 28, 1956</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>5-1-56</i>	
NAME OF CEMETERY OR CREMATORY <i>Woodlawn Memorial</i>		LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>4/30/56</i>		REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Md.</i>	

RECEIVED

MAY 2 1956

BUREAU V. S. )



4260

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1905 ARCOLA AVENUE</b>		d. STREET ADDRESS <b>1905 ARCOLA AVENUE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEOFFREY</b> Middle <b>MacDONALD</b> Last <b>NAIRN</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>19</b> Year <b>19 56</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/25/97</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POULTRYMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF-EMPLOYED</b>	11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>WILLIAM WALLACE NAIRN</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES NOERR</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES - WWI</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>MRS. MAE C. NAIRN, 1905 Arcola Ave.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary + thrombosis</b> <b>4/18/56</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>15:49</b> , 19 <b>56</b> , to <b>4:19</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/18/56</b> , 19 <b>56</b> , and that death occurred at <b>5:41</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Patrick C. Jameson</b>		DATE SIGNED <b>12020 Ga. Silver Spring, Md. 4/19/56</b>	
PHYSICIAN'S NAME (Type) <b>PATRICK C. JAMESON</b>		<b>12020 Ga. Ave., Silver Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	22b. DATE THEREOF <b>4/21/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>	22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>		24a. REC'D BY REGISTRAR <b>4/24/56</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Frances [illegible]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 23 1956

BUREAU V. A.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4166 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04245

Reg. Dist. No. 223

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Queens</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hills Long Island</u> d. STREET ADDRESS <u>9308 Queens Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Paul</u> Middle <u>Sam</u> Last <u>Nechamkus</u>				<b>4. DATE OF DEATH</b> Month <u>4</u> - Day <u>2</u> - Year <u>1956</u>									
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>10-5-1904</u>		<b>9. AGE</b> (In years last birthday) <u>51</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Musician</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Musician</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>New York</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Amer.</u>	
<b>13. FATHER'S NAME</b> <u>Sam Nechamkus</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Rose Nechamkus</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>  </u>				<b>17. INFORMANT</b> <u>Mrs. Helen Nechamkus - Forest Hills N.Y.</u> Address <u>9308 Queens Blvd.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>            IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>            420.1 DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u>            DUE TO (c) <u>  </u> </div> <div style="width: 15%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>1/2 hr</u> </div> </div>													
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>													
<b>20a. EXTERNAL CAUSE WAS</b> PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month, Day, Year <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
<b>ACTUAL SIGNATURE</b> <u>FRANK T. BOSCHERT</u>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>							
<b>EXAMINER'S NAME (Type)</b> <u>Frank T. Boschert</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>							
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						<b>DATE SIGNED</b> <u>4-2-56</u>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE TIME OF</b> <u>April 5, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>King David Mem. Garden</u>				<b>22d. LOCATION (City, town, or county)</b> <u>Falls Church Va.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>B. Naugausky &amp; Son</u>						<b>ADDRESS</b> <u>3501-14th St NW</u>							
<b>24a. REC'D BY REGISTRAR</b> <u>4/8/56</u>						<b>24b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>							

MEDICAL CERTIFICATION

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in line 18. Give pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ADONIS 8. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04246

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>3708 Oliver St.</u>	
3. NAME OF DECEASED (Type or print) <u>Lillian Mary O'Boyle</u>		4. DATE OF DEATH <u>April 23</u> 19 <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23, 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Scranton, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cornelius McDermott</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Gilleran</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(1) yes, give war or dates of service</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Daughter, Mrs. Clare Grimm - above</u>		Address: <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSION</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 DAY</u> <u>20 YR</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 23</u> , 19 <u>56</u> , to <u>April 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 23</u> , 19 <u>56</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leo I Donohue M.D.</u>		DATE SIGNED <u>4/23/56</u>	
PHYSICIAN'S NAME (Type) <u>LEO I DONOHUE M.D.</u>		ADDRESS (Street, city or town, state) <u>FO. 16 HENRY ST. WASH. D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-26-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Naulow</u>		ADDRESS <u>3831-GR. AVE. N.W.</u>	
24. REC'D BY REGISTRAR <u>4-23-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1971

1971

1971

1971

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4262

## CERTIFICATE OF DEATH

Reg. Dist. No.

042474

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON, SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON, SILVER SPRING</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11,718 LYTLE STREET</b>		d. STREET ADDRESS <b>3007 DAWSON AVENUE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>WILLIAMS</b> Last <b>O'BRIEN</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>18</b> Year <b>1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 7, 1891</b>
9. AGE (In years last birthday) <b>64 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>WADE HAMPTON WILLIAMS</b>		14. MOTHER'S MAIDEN NAME <b>EMMA DALTON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. WILLIAM W. O'BRIEN, 3107 DAWSON AVE.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic Glomerulonephrosis</b> DUE TO <b>Diabetic Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis -</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Arteriosclerosis -</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-30, 1953, to 4-18, 1956</b> , that I last saw the deceased alive on <b>4-17, 1956</b> , and that death occurred at <b>7:31 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Francis X. Richardson</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>7717-Alexander Ave. N.W. 4-19-56</b>	
PHYSICIAN'S NAME (Type) <b>Francis X. Richardson</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/21/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHN'S CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner B. Humphrey</b> ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>4/24/56</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Francis Vetter</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
APR 26 1956  
BUREAU Y. I.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4263

04248

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>104 George St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Cramer O'Brien</u>		4. DATE OF DEATH Month Day Year <u>4 - 20 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-25-84</u>
9. AGE (In years last birthday) yrs. <u>71</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Michael Obrien</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Cramer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Matilda Chamberlin - daughter</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, acute</u> DUE TO <u>4 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>2 weeks</u> (c) <u>Chemia Kellnerdion</u> 4 mos.		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of colon</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 9, 1954</u> , to <u>April 20, 1956</u> , that I last saw the deceased alive on <u>April 20, 1954</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Sharpe</u>		ADDRESS (Street, city or town, state) <u>10644 Connecticut Ave</u>	
PHYSICIAN'S NAME (Type) <u>George Sharpe M.D.</u>		DATE SIGNED <u>4-20-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-24-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Baller Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emmett L. Garrison</u>		ADDRESS <u>Gaithersburg Md</u>	
24a. REC'D BY REGISTRAR <u>4-24-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie W. Thompson</u>	

RECEIVED

APR 26 1956

BUREAU V. S.

4264

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
c. LENGTH OF STAY IN 1b <u>48 years</u>				d. STREET ADDRESS <u>3760 Howard Avenue</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3760 Howard Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Christine</u> Last <u>Palmer</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 31, 1882</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u> Hours <u>13</u> Min.		IF UNDER 24 HRS Months <u>7</u> Days <u>3</u> Hours <u>13</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>John A. Wagner</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Scherrer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Lillian Burton</u> Address <u>3760 Howard Avenue Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adenocarcinoma right kidney with metastases</u> DUE TO (b) <u>180x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>metastases</u> DUE TO (d) <u>2 1/2 years</u> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>180x</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec. 1, 1934</u> to <u>April 13, 1956</u> , that I last saw the deceased alive on <u>April 11, 1956</u> , and that death occurred at <u>2:43 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Katharine A. Chapman</u> M.D.				DATE SIGNED <u>April 13, 1956</u>			
PHYSICIAN'S NAME (Type) <u>Katharine A. Chapman</u>				<u>Kensington, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/16/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda</u>				24a. REC'D BY REGISTRAR <u>DATE 4-16-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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APR 18 1956

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, note exc-  
cute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be  
forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation,  
or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4265

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04250

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> D. C. b. COUNTY <u>none</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood</u>				c. LENGTH OF STAY IN 1b <u>3 mo</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>B70 #1</u>				d. STREET ADDRESS <u>1762 Columbia Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Theresa Marcelle Paxton</u>				4. DATE OF DEATH <u>Apr 28 1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-21-56</u>	
9. AGE (in years last birthday) <u>3</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Paxton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Social Service League - Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cyphria</u> DUE TO (b) <u>upper Respiratory Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>April 30, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Lukes</u>		22d. LOCATION (City, town, or county) (State) <u>Redland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raynor Barber</u>				ADDRESS <u>Laytonville MD</u>		24a. REC'D BY REGISTRAR <u>5-1-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Abundant Cooke</u>	

BUREAU V. E.

1956 7

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4266

## CERTIFICATE OF DEATH

04251

Reg. Dist. No. 266

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Maryland</b>		c. LENGTH OF STAY IN 1b <b>43 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Graham</b> Last <b>Pearce</b>		4. DATE OF DEATH Month <b>April</b> Day <b>24</b> , Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1885</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b>	IF UNDER 24 HRS. Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Graham</b>		14. MOTHER'S MAIDEN NAME <b>Emma McKinnon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b> <b>204.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute myelocytic leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE; CONDITION GIVEN IN PART I (a) <b>Pneumonia - left lower lobe. Generalized arteriosclerosis.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 12, 19 56</b> , to <b>April 24, 19 56</b> , that I last saw the deceased alive on <b>April 24, 19 56</b> , and that death occurred at <b>9:00 A.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Martin Schick</b>		DATE SIGNED <b>4/24/56</b>	
PHYSICIAN'S NAME (Type) <b>Martin Schick, M. D.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 4-26-56</b>		22b. DATE THEREOF <b>4-26-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine</b>		22d. LOCATION (City, town, or county) (State) <b>Logan Co. Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>4-25-56</b>	
ADDRESS <b>Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Bennett Thompson</b>	

BUREAU V. S.

APR 27 1900

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04252

4267

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN TB <b>one day</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		14-15-20 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNM, Bethesda, Md.</b>		d. STREET ADDRESS <b>3415 Rutgers Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>PENNELL</b>		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-13-1898</b>
9. AGE (In years last birthday) yrs. <b>58</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Swan Elison</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. (Daughter) <b>Hyattsville, Maryland</b>		18. (Daughter) <b>Marjorie KEESEY, 3415 Rutgers Street,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>hemorrhage, Cerebral</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>Indef.</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9 April</b> , 19 <b>56</b> , to <b>10 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10 April 1956</b> , and that death occurred at <b>12:30 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. J. Mc Carthy</b> M.D.		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>4-11-56</b>	
PHYSICIAN'S NAME (Type) <b>R. J. Mc Carthy, CDR, MC, USN</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-13-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b> <b>757 Wisc. Ave., Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>4-11-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary E. Passell</b>			

RECEIVED

APR 2

1964

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4268 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04253

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION, (If not in hospital, give street address) <u>Kensington Gardens Nursing</u>				d. STREET ADDRESS <u>3000 McComas Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LAURA</u> First <u>VIRGINIA</u> Middle <u>PERFECT</u> Last				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 15 1883</u>		9. AGE (last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis D Welbourne</u>				14. MOTHER'S MAIDEN NAME <u>Laura V. Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT Address <u>Lillian Brucher 3000 McComas Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis (Arteriosclerosis)</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Benign</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs. - 5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4-21-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Southern Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Neal Francis Home 4812 Galloway Rd</u> <u>Wash DC</u>				24a. REC'D BY REGISTRAR <u>4/24/56</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Francis J. Fuller</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please excuse the certificate, pending the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 1, 2, and 3 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 26 1956

BUREAU OF



BUREAU V. S.

APR 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4270

## CERTIFICATE OF DEATH

04255

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>103 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		d. STREET ADDRESS <b>1207-6<sup>1</sup>/<sub>2</sub> St., N. W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joyce</b> Middle <b>Elizabeth</b> Last <b>Porter</b>		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> , Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 17, 1939</b>
9. AGE (In years last birthday) <b>17 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Sylvester Shorter</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Phillips</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b> <b>204.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Necrosis of epiglottis. Monilia infection, pharynx, larynx</b> DUE TO (c) <b>Acute granulocytic leukemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>7 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. l. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 30, 1956</b> to <b>April 11, 1956</b> , that I last saw the deceased alive on <b>April 11, 1956</b> , and that death occurred at <b>4:37 A.</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Martin Schick</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/11/56</b>	
PHYSICIAN'S NAME (Type) <b>Martin Schick, M. D.</b>		<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>4-14-56</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Bethesda Md. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. S. Washington</b> ADDRESS <b>467 N st NW</b>		24a. REC'D BY REGISTRAR <b>4-14-56</b> 24b. REGISTRAR'S SIGNATURE <b>Gavie Campbell</b> <b>Mary E. Kennedy</b>	

MEDICAL CERTIFICATION

2

1

RECEIVED

APR 3 1956

RECEIVED



b. COUNTY

limits, write RURAL and give nearest town)

• IS RESIDENCE ON A FARM?  
YES ☐ NO ☒

Day	Year
10	57

Hours	Min.
-------	------

U.S.A.

UNKNOWN

Misc. Anne E. McHugh - above

(State)

DATE SIGNED \_\_\_\_\_

4/2/57

(Stote)

24b REGISTRAR'S SIGNATURE

240. REGISTRAR'S SIGNATURE  
B. M. L. ...

VS A15 (4)  
15M 9/55

11/11/1911

11/11/1911  
11/11/1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4272

## CERTIFICATE OF DEATH

04257

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Ranier</b>		d. STREET ADDRESS <b>2901 Queens Chapel Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>Evan</b> Last <b>RICHARDSON</b>		4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 4, 1895</b>
9. AGE (In years last birthday) yrs. <b>60</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Government Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Oregon</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>James G. RICHARDSON</b>		14. MOTHER'S MAIDEN NAME <b>Jane D. HUGHES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW-1 &amp; 2</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>(Wife) Mrs. Myrtle RICHARDSON</b>		2901 Queens Chapel Rd. Mt. Ranier, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: <b>Squamous CA., pharynx, with metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>26 March</b> , 19 <b>56</b> , to <b>15 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>15 April</b> , 19 <b>56</b> , and that death occurred at <b>1120 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>			
ACTUAL SIGNATURE <b>Robert L. King, Jr.</b> M.D.		PHYSICIAN'S NAME (Type) <b>Robert L. KING, Jr., CDR, MC, USN U.S. Naval Hospital, NNMC, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>19 Apr. 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington, Virginia</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. PUMPHREY FUNERAL HOME</b> <b>7557 Wisconsin Ave., Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>4-16-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Bay E. Gansell</b>			

REAU V. S.

APR 18 1956

RECEIVED

4174

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Horners Lane</b>				d. STREET ADDRESS <b>Horners Lane</b>			
3. NAME OF DECEASED (Type or print) <b>EDWIN</b> First <b>G.</b> Middle <b>RIGGS</b> Last				4. DATE OF DEATH <b>April 11, 1956</b> Month <b>April</b> Day <b>11</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 4, 1893</b>	9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months <b>8</b> Days <b>7</b>	IF UNDER 24 HRS. Hours <b>7</b> Min <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Firefighting</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Riggs</b>				14. MOTHER'S MAIDEN NAME <b>Margaret G. Graham</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Roger Bean-Rockville, Maryland</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure &amp; aspiration</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Bronchial pneumonia &amp; metastasis</b> DUE TO (c) <b>Carcinoma of rectum</b>							INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>2 weeks.</b> <b>5 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/3/56</b> to <b>4/11/56</b> , that I last saw the deceased alive on <b>4/11/56</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stephen D. Jones</b> M.D.				ADDRESS (Street, city or town, state) <b>Rockville, Md.</b>		DATE SIGNED <b>4/11/56</b>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/14/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Union</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda</b>				24a. REC'D BY REGISTRAR DATE <b>4/16/56</b>		24b. REGISTRAR'S SIGNATURE <b>Laurel H. Bryant</b>	
				<b>Maryland</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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95.1 1956

10/10/11 00:00:00

4273

# CERTIFICATE OF DEATH

04259  
216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Maryland</b>		c. LENGTH OF STAY IN 1b <b>22 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		e. IS RESIDENCE C. A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lucy</b> Middle <b>Has</b> Last <b>Rowland</b>		4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>1956</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 20, 1894</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government work</b>	
11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac Rowland</b>		14. MOTHER'S MAIDEN NAME <b>Julia Garrow</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>not available</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda, 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE LIVER NECROSIS</b> <b>175x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>APLASTIC ANEMIA</b> DUE TO (c) <b>CARCINOMA OF OVARIES WITH METASTASES</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 5, 1956</b> , to <b>April 27, 1956</b> , that I last saw the deceased alive on <b>April 27, 1956</b> , and that death occurred at <b>1:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Horace Herbsman</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>4/30/56</b>		22b. DATE THEREOF <b>4/30/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>		22d. LOCATION (City, town, or county) <b>Kansas City, Mo.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>4/30/56</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

RECEIVED

MAY 2 1956

BUREAU V. S.



4167

## CERTIFICATE OF DEATH

Reg. Dis. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Maryland</u>			
c. LENGTH OF STAY IN TB <u>3 hours</u>				d. STREET ADDRESS <u>2407 Hanner St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Joseph</u> Last <u>Rubino</u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 9 1917</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Liquor Dist. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>John B. Rubino</u>				14. MOTHER'S MAIDEN NAME <u>Mary Fiano</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>✓</u>				16. SOCIAL SECURITY NO. <u>578-10-0136</u>			
17. INFORMANT <u>Mrs. Josephine M. Rubino</u>				Address <u>- same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery (Heart Disease)</u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 22 1956</u> to <u>April 22 1956</u> , that I last saw the deceased alive on <u>April 22 1956</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert B. Irey</u>				ADDRESS (Street, city or town, state) <u>7105 Riggs Rd. Hyattsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert B. Irey</u>				DATE SIGNED <u>4-22-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Belmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley Funeral Home</u>				ADDRESS <u>3200 R.I. Ave.</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>  </u>	
				24b. REGISTRAR'S SIGNATURE <u>  </u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 27 1956

BUREAU Y. S.

4274

## CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		STATE MARYLAND		COUNTY MONTGOMERY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN WHEATON		1 YR.		TOWN WHEATON			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2911 COLLINS AVENUE				STREET ADDRESS (If rural give location) 2911 COLLINS AVENUE			
3. NAME OF DECEASED (Type or Print)		(First) ANNIE (Middle) MAY (Last) RUFFNER		4. DATE OF DEATH		(Month) APRIL 12 (Day) 19 (Year) 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH SEPT. 20, 1872	9. AGE last birthday 83 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN KING				14. MOTHER'S MAIDEN NAME EMMA MAE JANES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		(If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS Mrs. Clarence E. Roberts, 2911 Collins Ave., Wheaton, Md.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Acute Coronary Infarction, septum of heart						INTERVAL BETWEEN ONSET AND DEATH 1 day	
ANTECEDENT CAUSE(S) DUE TO Coronary Heart Disease						June 19 55	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Arteriosclerosis							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-13-1955, to April 12, 1956, that I last saw the deceased alive on April 12, 1956, and that death occurred at 11:30 AM, from the causes and on the date stated above.							
SIGNATURE J. D. Williams				ADDRESS (Street, city, town, state) DATE SIGNED M.D. 249 Missouri Avenue, N.W. Wash. D.C. 4-13-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 4/16/56		NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
24. REC'D BY REGISTRAR DATE 4/17/56		REGISTRAR'S SIGNATURE Frances Folger		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Warner & Pumphrey, SILVER SPRING, MD.			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been recorded by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. B.

APR 19 1930

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4275 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04262

Reg. Dist. No. 214

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>1 yr</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1905 East West Highway</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1905 East West Highway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Estelle</u> Middle <u>Sammels</u> Last <u>Sammels</u>		<b>4. DATE OF DEATH</b> Month <u>Apr</u> Day <u>24</u> Year <u>1956</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>8-12-93</u> <b>9. AGE</b> (In years last birthday) <u>62 yrs.</u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>N.Y.C.</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>N.Y.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Ralph Jacob</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Betha Wilson</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <u>None</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>Maurice Samuels (husband)</u> Address <u>Same as</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 31X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> a. m. _____ p. m. _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Brosch</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>Frank J. Brosch</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>4-24-56</u>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>cremation</u>		<b>22b. DATE THEREOF</b> <u>4/25/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft. Lincoln Crematory</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S.H. Hines Co.</u> ADDRESS <u>Wash, 9, D.C.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>4/25/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Francis J. ...</u>			
<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>Pr. Geo. Co., Maryland</u>		<b>24d. LOCATION (City, town, or county)</b> _____ (State) _____					

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please excuse the certificate, giving the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
APR 30 1956  
BUREAU V. S.

4276

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Seneca</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Seneca</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD # 1, Poolesville</b>		d. STREET ADDRESS <b>RDF # 1, Poolesville</b>	
3. NAME OF DECEASED (Type or print) <b>ANNA</b> First Middle Last <b>SANCOMB</b>		4. DATE OF DEATH <b>April 9, 1956</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-6-1893</b>
9. AGE (In years last birthday) <b>62</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>George Storm</b>	
14. MOTHER'S MAIDEN NAME <b>Mary E. Sullivan</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Howard G. Sancomb- Item # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> DUE TO <b>Carcinoma Panceras gland</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>6 months</b> (c) <b>157X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>none</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 1955</b> to <b>April 1956</b> , that I last saw the deceased alive on <b>April 1956</b> , and that death occurred at <b>6:05 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>P.O. Boyd, Md</b> DATE SIGNED ACTUAL SIGNATURE <b>John Fawcett</b> M.D. <b>Boyd, Maryland</b> PHYSICIAN'S NAME (Type) <b>John Fawcett</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-11-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 4/10/56</b>	24b. REGISTRAR'S SIGNATURE <b>Lawell H. Bryant</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1911



Division of Special Collections



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4277 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04264

Reg. Dist. No. 218

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R-1</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Goshen Rd.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R-1</u> d. STREET ADDRESS <u>Goshen Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Dale Lee Santos</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>apr 24 1956</u>			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>2-14-56</u>		<b>9. AGE</b> <u>4</u> years <u>2</u> months <u>10</u> days IF UNDER 1 YEAR: Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>mass</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>usa</u>				<b>13. FATHER'S NAME</b> <u>Jose Francis Santos Jr.</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Gladys Merrick (mother)</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service)			
<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address <u>Same as Street 14</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Asphyxia due to vomiting</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> DUE TO (c)							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschert</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschert</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>4-24-56</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>April 24, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>GOSHEN</u>		<b>22d. LOCATION (City, town, or county) (State)</b> <u>Gaithersburg Maryland</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ray W. Barker</u> ADDRESS <u>Laytonsville, Md.</u>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>4-26-56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Aberda J. Cook</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

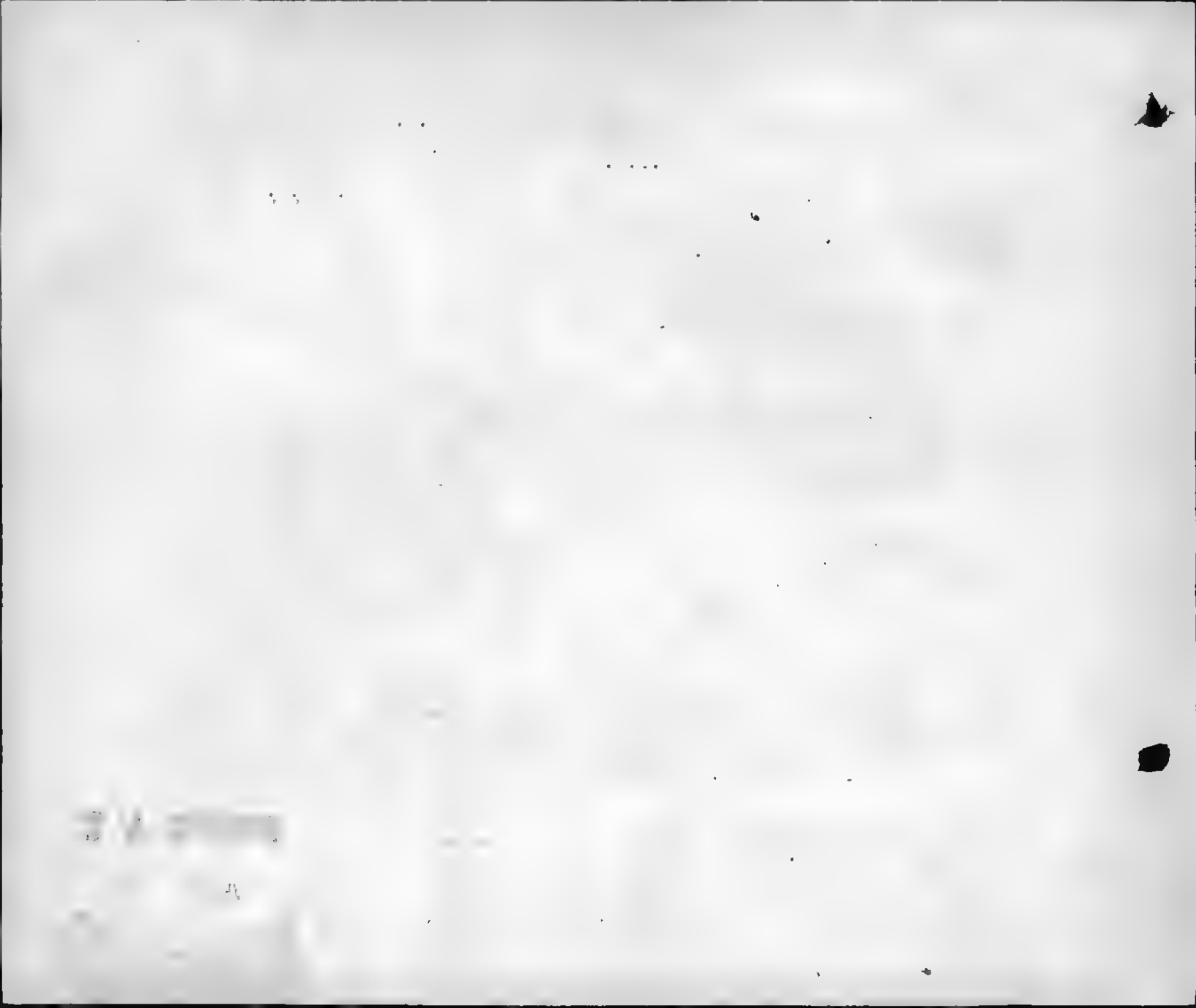
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
APR 3 1900  
BUREAU V. S.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8, 22b: film G190 5-1-56

VS. A15ME(5)  
SM 9/55



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the executor should be the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04266

## 4279 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1 1/2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>11313 NORRIS DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>FRANK Phillip Scherrer</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>4-4-56</u>					
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>12-18-68</u>		<b>9. AGE</b> (In years last birthday) <u>87 yrs.</u> <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>gardener</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Philip Scherrer</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Catherine Schrieder</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>214-28-4989</u>		<b>17. INFORMANT</b> Address <u>Elana Quinter - Sister</u> <u>11313 NORRIS DRIVE Kensington, Md.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>malpractice trauma by automobile</u> (c)								INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hrs.</u> <u>3 1/2 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right humeral humeral fracture humeral fracture</u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of Item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>7:03 am</u> <u>4-4-1956</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>11415 Chesmill Rd Silver Spring Md</u>		<b>20f. (City or town)</b> (County) (State) <u>Silver Spring Md</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>EXAMINER'S NAME</b> (Type) <u>FRANK J. BROSCART</u>				<u>4-4-56</u>					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>4/7/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>ROCK CREEK CEMETERY</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>WASHINGTON, D. C.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>Warner E. Humphrey, SILVER SPRING, MD.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>4/7/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Bessie M. Thompson</u> <u>Ru LH</u>			

White  
Black  
Yellow  
Red  
Green  
Blue  
Purple  
Brown

July 1996

' 44

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4280

CERTIFICATE OF DEATH

Reg. Dist. No. 0426716

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. LENGTH OF STAY IN 1b <i>1 month</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				d. STREET ADDRESS <i>2903 Kingswell Drive</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>SUSAN A.</i> Middle <i>Scoley</i> Last <i>Scoley</i>				4. DATE OF DEATH Month <i>April</i> Day <i>20</i> Year <i>1956</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-4-81</i>	
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Iowa</i>	
12. CITIZEN OF WHAT COUNTRY? <i>US</i>							
13. FATHER'S NAME <i>Vincent Dejo</i>				14. MOTHER'S MAIDEN NAME <i>Huldah Chidester</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>509-22-1181</i>		17. INFORMANT Address <i>Miriam Cunningham - SAME</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of lung</i> DUE TO (c) <i>Emphysema</i>							INTERVAL BETWEEN ONSET AND DEATH <i>8 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Feb</i> 1956, to <i>April 20</i> 1956, that I last saw the deceased alive on <i>April 20</i> 1956, and that death occurred at <i>10:00 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>George Sharpe</i> M.D. <i>10644 Connecticut Ave NW</i>				DATE SIGNED <i>4-10-57</i>			
PHYSICIAN'S NAME (Type) <i>George Sharpe</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>TRANS &amp; BURIAL</i>		22b. DATE THEREOF <i>4/23/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>GREAT BEND CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>GREAT BEND, KANSAS</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter E. Humphrey</i> ADDRESS <i>SILVER SPRING, MD.</i>				24a. REC'D BY REGISTRAR <i>4-23-56</i>		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

1950





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04268

4281

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Maryland</b>		c. LENGTH OF STAY IN 1b <b>31 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		e. STREET ADDRESS <b>313 W. Race Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Rosemargaret</b> Last <b>Shade</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> , Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1927</b>
9. AGE (In years last birthday) yrs. <b>29</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Leo Rice</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Byer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive heart attack terminal heart disease</b> 2041 DUE TO <b>Thrombolytic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Ante myocardial infarction</b> (c) <b>Ante myocardial infarction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 13, 1956</b> , to <b>April 13, 1956</b> , that I last saw the deceased alive on <b>April 13, 1956</b> , and that death occurred at <b>2:25 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Martin Schick</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Martin Schick, M.D.</b>		DATE SIGNED <b>4-13-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-16-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Allegheny Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Funeral Home</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>4-16-56</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

RECEIVED

APR 18 1956

BUREAU V.

VS. A15ME(S)  
SM 9/55

SIGNATURE *E. P. Russell*

BUREAU V. S.

MAY 2 1956

RECEIVED

4283

CERTIFICATE OF DEATH

04270

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillside</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>1512 59th Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Albert</b> First Middle <b>(n)</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-10-05</b>
9. AGE (In years last birthday) <b>50 yrs.</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mariner Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Edward J. SMITH</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>577 42 5211</b>	
17. INFORMANT <b>Wife Mrs. Sarah G. SMITH</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke, thrombotic</b> DUE TO (b) <b>Subepit. abscess</b> DUE TO (c) <b>Osteosarcoma, metastatic invasive</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b> <b>1 mo.</b> <b>6 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6 Apr</b> , 19 <b>56</b> , to <b>20 Apr</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>20 Apr</b> , 19 <b>56</b> , and that death occurred at <b>11:27 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. J. Rupnik</b>		ADDRESS (Street, city or town, state) <b>USNH, NMMC, Bethesda, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>E. J. RUPNIK LCDR, MC, USN</b>		DATE SIGNED <b>4-20-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>24 Apr 56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ryan Funeral Home</b>		24a. REC'D BY REGISTRAR <b>24b. REGISTRAR'S SIGNATURE</b>	
317 Penn Avenue, N.W. Wash D.C.		DATE <b>21 Apr 56</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: Enter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 1 1950

DOUGLAS A. J.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4284 CERTIFICATE OF DEATH

04271

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
c. LENGTH OF STAY IN 1b <u>11 days</u>		d. STREET ADDRESS <u>129 Grafton St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alexander H. Sonnemann</u>		4. DATE OF DEATH Month Day Year <u>Apr 26 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 20 1871</u>
9. AGE (In years last birthday) yrs. <u>84</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>11 6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ottmar Sonnemann</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Cox</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>patient</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cv disease + cardiac enlargement</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 15, 1956</u> to <u>April 26, 1956</u> , that I last saw the deceased alive on <u>4/26/1956</u> , and that death occurred at <u>5:55 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Ziegler</u> M.D.		DATE SIGNED <u>4-26-56</u>	
PHYSICIAN'S NAME (Type) <u>John B. Ziegler</u>		<u>Olney Maryland</u> <u>4-26-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-30-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>4-28-56</u> 24b. REGISTRAR'S SIGNATURE <u>Katherine B. Lawley</u>	

U.S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04272

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>84 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md.</b>		d. STREET ADDRESS <b>410 Forrestview Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Genevieve</b> Middle <b>Rictchie</b> Last <b>Stauffer</b>		4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 16, 1902</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Lewis Rictchie</b>	
14. MOTHER'S MAIDEN NAME <b>Emma Walker</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record Address The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Biliary nephrosis and hepatic coma</b> DUE TO (b) <b>metastatic breast cancer</b> DUE TO (c) <b>Carcinoma, right breast</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>hemorrhagic diathesis due to thrombocytopenia</b>			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January 11, 1956</b> , to <b>April 4, 1956</b> , that I last saw the deceased alive on <b>April 4, 1956</b> , and that death occurred at <b>1:27 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert S. Mendelsohn</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Robert S. Mendelsohn</b>		DATE SIGNED <b>4/4/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Apr 7 1956</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenhill</b>		22d. LOCATION (City, town, or county) (State) <b>Wilmington Del</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm W. Smith - 1217 St Paul St</b>		24a. REC'D BY REGISTRAR <b>APR 6</b>	
24b. REGISTRAR'S SIGNATURE <b>Mrs. Bessie Thompson</b>			



1 A 111111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04273

4286

## CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
c. LENGTH OF STAY IN 1b 2 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,303 HAYWOOD DRIVE		d. STREET ADDRESS 1703 HIGHLAND DRIVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last BERTHA HOLT STEWART		4. DATE OF DEATH Month APRIL Day 27 Year 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 31, 1862
9. AGE (In years last birthday) 93 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) GERMANTOWN, PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHALKLEY HOLT		14. MOTHER'S MAIDEN NAME RACHEL RITTENHOUSE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address MRS. CLIFFORD E. WALLER, 10303 Haywood Dr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 451X Dissecting abdominal aortic aneurysm DUE TO (b) Atherosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Decompensation		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 to 27 April, 1956, that I last saw the deceased alive on 27 April, 1956, and that death occurred at 8:30 PM, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE WILLIAM D. AUD M.D. 9006 Colesville Rd., Silver Spring, Md. 4/27/56			
PHYSICIAN'S NAME (Type) WILLIAM D. AUD		9006 COLESVILLE ROAD, SILVER SPRING, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/1/56	
22c. NAME OF CEMETERY OR CREMATORY FRIENDS CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wanner E. Humphrey, SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 4/30/56	
		24b. REGISTRAR'S SIGNATURE Frances E. Blum	

BUREAU V. S.

1956

7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film 496 5-7-56 at

4168

## CERTIFICATE OF DEATH

04274

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash San + Hosp</u>				d. STREET ADDRESS <u>Rileysville</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DELIA Stoneberger</u>				4. DATE OF DEATH Month Day Year <u>4 27 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-15-1911</u>	
9. AGE (In years last birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Thomas Nicholas</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Nicholas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thromboembolism</u> DUE TO <u>Congestive Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hemorrhage</u> (c) <u>Cerebral Hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 weeks</u> <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>4-15-1956</u> , to <u>4-27-1956</u> , that I last saw the deceased alive on <u>4-26-1956</u> , and that death occurred at <u>5:28 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.				ADDRESS (Street, city or town, state) <u>809 Davis Ave.</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>				DATE SIGNED <u>Takoma Park Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4-29-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Int. Home</u>		22d. LOCATION (City, town, or county) (State) <u>Rileysville Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. C. Bradley - Ivey, Va.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>4/27/56</u>	
						24b. REGISTRAR'S SIGNATURE <u>John D. Dill</u>	

BUREAU V. S.

APR 27 1900

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4287 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04275

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4927 Cordell Ave</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>4927 Cordell Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Esmoneel</u> First <u>Keyser</u> Middle <u>Sunday</u> Last <b>4. DATE OF DEATH</b> <u>Apr</u> Month <u>21</u> Day <u>1956</u> Year				<b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>10-19-91</u> <b>9. AGE</b> (In years last birthday) <u>64</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Antique dealer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Pennsylvania</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>13. FATHER'S NAME</b> <u>Jacob G. Sunday</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth L. Smith</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>Evangeline B. Sunday-Item # 2</u> Address				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>Strangulation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Strangulation</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in store</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Hung self by neck with 1/2 in rope</u>			
<b>20c. TIME OF INJURY</b> Hour <u>19</u> a. m. p. m. Month, Day, Year <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>store</u> <b>20f. (City or town)</b> <u>Bethesda</u> (County) <u>Montg</u> (State) <u>MD</u>			
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschek</u> <b>EXAMINER'S NAME</b> (Type) <u>FRANK J. BROSCHEK</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u> <b>22b. DATE THEREOF</b> <u>4-24-56</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill</u> <b>22d. LOCATION</b> (City, town, or county) <u>Suitland</u> (State) <u>Maryland</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey-Bethesda, Maryland</u> <b>ADDRESS</b>				<b>24a. REC'D BY REGISTRAR</b> <u>4-22-56</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Bessie M. Thompson</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the executor of the certificate, making the "pending" in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 23 1956

RECEIVED



## CERTIFICATE OF DEATH

Reg. Dist. No. 216.....

4288

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Ind.</i>	COUNTY <i>Montgomery</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Bethesda</i>	LENGTH OF STAY (in this place) <i>1 wk 3 da</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Bethesda</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Alta Vista Rest Home</i>		STREET ADDRESS (If rural give location) <i>6915 Strathmore st.</i>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <i>Benjamin</i>	(Middle) <i>Franklin</i>	(Last) <i>Taylor</i>	DATE OF DEATH: <i>Apr. 13 1956</i>
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH: <i>July 28, 1865</i>
9. AGE last birthday: <i>90</i> yrs. <i>8</i> Months <i>15</i> Days <i></i> Hours <i></i> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Retired</i>	
11. BIRTHPLACE (State or foreign country): <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.</i>	
13. FATHER'S NAME: <i>Mahlon Taylor</i>		14. MOTHER'S MAIDEN NAME: <i>Merciana Yardley?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT & ADDRESS: <i>Mrs. Ridgeway Taylor</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(A) IMMEDIATE CAUSE <i>Bronchopneumonia</i>		<i>3 days</i>
(B) ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <i>1/5/56</i> , 19 .., to <i>4/13</i> .., 1956 that I last saw the deceased alive on <i>4/13</i> .., 1956, and that death occurred at <i>2:00 P.M.</i> , from the causes and on the date stated above.			
SIGNATURE <i>Dr. Joseph Kurrieb</i>		ADDRESS <i>M.D. 6450 Wisconsin Ave, Beth Md</i>	
DATE SIGNED <i>4/13/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial-transit</i>	DATE THEREOF <i>4/15/56</i>	NAME OF CEMETERY OR CREMATORY <i>St. Mary's</i>	LOCATION (City, town, or county) (State) <i>Burlington Co. New Jersey</i>
DATE REC'D BY LOCAL REGISTRAR <i>4-16-56</i>	REGISTRAR'S SIGNATURE <i>Bessie M Thompson</i>	24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>	ADDRESS <i>Bethesda, Maryland</i>

MARGIN RESERVED FOR BINDING

BUREAU V.

APR 18 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4289 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

042774  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOHN'S SCHOOL HALL</b>				d. STREET ADDRESS <b>1710 DONALD PLACE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HAROLD</b> Middle <b>S.</b> Last <b>TAYLOR</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>14</b> Year <b>19 56</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/5/13</b>		9. AGE (In years last birthday) <b>42</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Universal Pictures</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester, Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HAROLD S. TAYLOR</b>				14. MOTHER'S MAIDEN NAME <b>GRACE MEEHAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>012-10-2472</b>		17. INFORMANT Address <b>Mrs. M. Loretta Taylor, 1710 Donald Place Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>            42001 DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____            DUE TO (c) _____</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/17/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHN'S CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>				ADDRESS <b>SILVER SPRING, MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>4/17/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Frances Turner</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the examiner should file the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. T.

APR 19 1956

RECEIVED

4169

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>the District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hosp.</u>				d. STREET ADDRESS <u>3900 - 16th St N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mate</u> Middle <u>(no)</u> Last <u>Thurtell</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-16-71</u>	
9. AGE (In years last birthday) <u>85 yrs.</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
13. FATHER'S NAME <u>Charles Snow</u>				14. MOTHER'S MAIDEN NAME <u>Maria Morrison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Hospital Records</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure Long Heart Failure</u> DUE TO (b) <u>Hypertensive Cardiac disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic Nephritis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Obesity - Chronic Asthma</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>April 13, 1956</u> to <u>April 19, 1956</u> , that I last saw the deceased alive on <u>April 18, 1956</u> , and that death occurred at <u>5:50</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Eanet</u> M.D.				ADDRESS (Street, city or town, state) <u>6727-16th NW</u> DATE SIGNED <u>4-19-56</u>			
PHYSICIAN'S NAME (Type) <u>PAUL EANET M.D.</u>							
22a. BURIAL (CREMATION, REMOVAL (Specify) <u></u>		22b. DATE THEREOF <u>4-28-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Eanet</u> ADDRESS <u>812 Pine Ave NW</u>				24a. REC'D BY REGISTRAR <u>J. Wilson Dodd</u>		24b. REGISTRAR'S SIGNATURE <u></u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4290

## CERTIFICATE OF DEATH

Reg. Dist. No.

04279  
276

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4526 Drummond Ave</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>Cherry Chase, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elisabeth Winship Tibbott</u>		4. DATE OF DEATH Month Day Year <u>April 7 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1863</u>
9. AGE (In years last birthday) <u>92</u> yrs		IF UNDER 1 YEAR Months Day Hours Min. <u>7 15</u>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward K. Winship</u>	
14. MOTHER'S MAIDEN NAME <u>Carolyn Bachman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Son - Lloyd Tibbott - above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumo, right lower lobe, with abscess</u> DUE TO (b) <u>471x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>471x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic secondary to severe nephrosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4.1.1956</u> , to <u>4.7.1956</u> , that I last saw the deceased alive on <u>4.7.1956</u> , and that death occurred at <u>4.50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Stewart Clapp M.D. 3921 Ingomar St. N.W. Wash. D.C. 4.7.56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>4/11/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 4/10/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File page 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4291 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 042806

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> <u>Kensington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DE</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MONTGOMERY CO</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>		e. STREET ADDRESS <u>6600 Luzon Ave NW</u>	
3. NAME OF DECEASED (Type or print) First <u>CARRIE</u> Middle <u>TRUPP</u> Last		4. DATE OF DEATH Month <u>APRIL</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 1, 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>58</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SOLOMON</u>		14. MOTHER'S MAIDEN NAME <u>ANNA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>SAM TRUPP</u>		Address <u>6600 Luzon Ave NW</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage -</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis general -</u> DUE TO (c) <u>Cerebral Fibrillation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural cause</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Samuel Allen MD</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/16/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bnai Israel</u>	22d. LOCATION (City, town, or county) (State) <u>Oxon Hill Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Wash. DC</u>		24a. REC'D BY REGISTRAR DATE <u>4-18-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

BUREAU V. S.

APR 20 1950

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BUREAU V. S.

MAY 3 1956

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04282**  
**4293 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 211

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float:right">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u> c. LENGTH OF STAY IN 1b <u>5 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mrs. Drake Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u> d. STREET ADDRESS <u>9 Jefferson Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Ada</u> Middle <u>Walker</u> Last <u>Walker</u>				<b>4. DATE OF DEATH</b> Month <u>Apr</u> Day <u>21</u> Year <u>1956</u>											
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Jan 1876</u>		<b>9. AGE</b> (In years last birthday) <u>80</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housework</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Ill</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Unknown</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>				<b>17. INFORMANT</b> <u>MRS. DRAKE</u>				<b>Address</b> <u>DAMASCUS, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c), stating the underlying cause lost. DUE TO (c) <u>  </u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>sudden</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>															
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> <b>M.D.</b>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DATE SIGNED</b> <u>4-21-56</u>			
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. BROSCART</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>APRIL 24, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>GEORGE WASHINGTON</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>CEM RIGGS RD, HATTIESVILLE PR GEO G. Md.</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles Stalder</u>						<b>ADDRESS</b> <u>254 CARROLL ST NW. D.C.</u>		<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>John H. Buntley</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 23 1957

FILE

4294

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gumantown</u>	
		d. STREET ADDRESS <u>P.O. Box 53</u>	
3. NAME OF DECEASED (Type or print) First <u>Horace</u> Middle <u>Elsworth</u> Last <u>Wallik</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-20-97</u>
9. AGE (In years last birthday) <u>58</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Basil Crawford Wallik</u>		14. MOTHER'S MAIDEN NAME <u>Martha Bennett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Kenneth Wallik - son</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden ventricular failure</u> DUE TO <u>Severe aortic and mitral valvulostenosis</u> DUE TO <u>Severe Rheumatic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 1954, to <u>Apr. 28</u> , 1956, that I last saw the deceased alive on <u>April 28</u> , 1956, and that death occurred at <u>4:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) <u>3421 Ingomar St. N.W. Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>		DATE SIGNED <u>4.29.56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-5-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Garrison</u>		ADDRESS <u>Guithersburg Md.</u>	
24a. REC'D BY REGISTRAR <u>5-1-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 3 1900

RECEIVED



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

04284

## 1. PLACE OF DEATH

County Montgomery CountyVillage or City Silver Spring, Maryland

Registration Dist. No.

No. 9416 Worth AvenueSt. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U.S. if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## 2. FULL NAME

Mr. Allen Beckley Ward(a) Residence: No. 9416 Worth Avenue St. Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of <u>Pearle Witter Ward</u>		
6. DATE OF BIRTH (month, day, and year) <u>July 30, 1884</u>		
7. AGE Years <u>71</u>	Months <u>8</u>	Days <u>3</u>
If LESS than 1 day, _____ hrs. _____ min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER SAWYER, BOOKKEEPER, etc. <u>Construction Engineer</u>	
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>U. S. Government</u>	
	10. Date deceased last worked at this occupation (month and year) _____	
		11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (city or town) New York City  
(State or country) New York13. NAME Moses Willson Ward14. BIRTHPLACE (city or town) Canaan,  
(State or country) Ohio15. MAIDEN NAME Rosalie A. Beckley16. BIRTHPLACE (city or town) Forestville  
(State or country) Connecticut17. INFORMANT Mrs. Pearle W. Ward  
(Address) 9416 Worth Ave., Silver Spring, Md.18. BURIAL, CREMATION, OR REMOVAL Trans. & Entombment  
Place Rural Cemetery, Worcester, Mass. Date April 4, 195619. UNDERTAKER Warren & Humphrey  
(Address) 8434 Ga. Ave., Silver Spring, Md.20. FILED 4/4/56 Francis Potter  
Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

April 3, 1956  
(Month) (Day) (Year)22. I HEREBY CERTIFY that I attended deceased from August 7, 1951 to April 3, 1956I last saw him alive on April 3, 1956; death is said to have occurred on the date stated above, at 3:50 PM

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Lobular Pneumonia, bilateralDate of page 4/7/56

Other Contributory Causes of Importance:

Cancer, Prostatic - generalized metastasis

5/27/55

Name of operation Prostatectomy Date of 5/27/55What test confirmed diagnosis? Lab. Tissue Section Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify \_\_\_\_\_

(Signed) Francis Potter M. D.  
(Address) 3805 McKinley St. N.W., D.C. (15)

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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## Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

1  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**4296**

**CERTIFICATE OF DEATH**

**04285**

Reg. Dist. No. **215**

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>District of Columbia</b> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>		d. STREET ADDRESS <b>1430 Belmont St., N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Melciah</b> Middle <b>John</b> Last <b>WASHINGTON</b>		4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negroid</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 23, 1898</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Resturant</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW-1</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Edna WASHINGTON, wife (Same as #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary atherosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>undetermined</b> <b>6 1</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>5</b> a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>15 April</b> , 19 <b>56</b> , to <b>22 April</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>22 April</b> , 19 <b>56</b> , and that death occurred at <b>10:55P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>4-23-56</b>	
PHYSICIAN'S NAME (Type) <b>H.A. SCHLANG, CDR, MC, USN</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-27-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. Jarvis &amp; W. E. Jarvis Funeral Home</b> <b>1430 Belmont St., N.W. Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE 4-23-56</b>	24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 24 1956

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4297

## CERTIFICATE OF DEATH

04286

Reg. Dist. No. 296

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradley Farms, Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradley Farms, Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9306 Kendale Road</b>		d. STREET ADDRESS <b>9306 Kendale Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Waterman</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1956</b> <b>EX</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1901</b>
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Nova Scotia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Canada</b> <input checked="" type="checkbox"/>	
13. FATHER'S NAME <b>Rufus Parks</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Corkum</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Arthur J. Waterman</b>		Address <b>9306 Kendale Road Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.0</b> DUE TO <b>Coronary Sclerotic Heart Disease</b> 10 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Essential Arterial Hypertension</b> 15 yrs. (c) <b>Essential Arterial Hypertension</b> 15 yrs. INTERVAL BETWEEN ONSET AND DEATH <b>1 minute</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Apr 14, 1956</b> to <b>Apr 17, 1956</b> , that I last saw the deceased alive on <b>4-13</b> , 1956, and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Hill Carter</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>4-17-56</b>	
PHYSICIAN'S NAME (Type) <b>HILL CARTER</b>		M.D. <b>1835 Eye St NW</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/19/1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Montgomery County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. W. Niles Co.</b>		ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>	
24a. REC'D BY REGISTRAR <b>DATE 4-15-56</b>		24b. REGISTRAR'S SIGNATURE <b>Deane M. ...</b>	

BUREAU V. S.

APR 10 1911

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4298

## CERTIFICATE OF DEATH

04287

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hosp.</b>		d. STREET ADDRESS <b>5127 River Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Cyrus</b> Middle <b>Watkins</b> Last <b>Watkins</b>		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. ? 1884</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR: Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur and Landscaping</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aiken, S.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Kimmy Watkins</b>		14. MOTHER'S MAIDEN NAME <b>Jeanette Hallman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>Wife- Ella m. Watkins above</b>	
17. INFORMANT <b>Wife- Ella m. Watkins above</b>		Address <b>above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>massive cerebral hemorrhage</b> DUE TO (b) <b>rupture, left lenticulo-striate artery</b> DUE TO (c) <b>cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>7 days</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Adenocarcinoma prostate</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 24</b> , 19 <b>56</b> , to <b>May 30</b> , 19 <b>56</b> that I last saw the deceased alive on <b>May 30</b> , 19 <b>56</b> , and that death occurred at <b>9:05 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		ADDRESS (Street, city or town, state) <b>Suburban Hosp. Bethesda 14 D.C.</b>	
PHYSICIAN'S NAME (Type) <b>J. E. ASH</b>		DATE SIGNED <b>May 31</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 4, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Rhines &amp; Co.</b>		ADDRESS <b>901 3rd Street, S. W.</b>	
24a. REC'D BY REGISTRAR <b>5-4-56</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BURNETT W. S.

MAY 4 1956

RECEIVED



4299

CERTIFICATE OF DEATH

04288

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Vernon</u> Middle <u>Dorsey</u> Last <u>Watkins</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 5 1865</u>
9. AGE (In years last birthday) <u>90</u> yrs		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Surveyor &amp; Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomas Watkins</u>		14. MOTHER'S MAIDEN NAME <u>Mary Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Hospital Record</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular-renal disease with</u> <u>442X</u> DUE TO <u>Terminal uremia.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Terminal Broncho-pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>25 yrs</u> <u>25 yrs</u> <u>1 week</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Patient fell out of bed 4 days prior to admission spraining</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>back</u> <u>? Possible contributing cause.</u>
20c. TIME OF INJURY Month, Day, Year Hour <u>4 a.m.</u> p. m. <u>3-21-56</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>RFD Gaithersburg, Md.</u>

21. I certify that I attended the deceased from March 21, 1956, to April 9, 1956, that I last saw the deceased alive on April 8, 1956, and that death occurred at 7:55a M., from the causes and on the date stated above.

ACTUAL SIGNATURE M. McKendree Boyer M.D. Damascus, Md.  
ADDRESS (Street, city or town, state) DATE SIGNED

PHYSICIAN'S NAME (Type) McKendree Boyer, M.D. Druid Theatre Building, Damascus, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>April 12 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Providence Reformatory Md.</u>	22d. LOCATION (City, town, or county) (State) <u>Fredrick Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W Barber</u>		24a. REC'D BY REGISTRAR <u>Loftonville Md</u>	24b. REGISTRAR'S SIGNATURE <u>Gertrude B Lawler</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

BUREAU V. S.

APR 1

RECEIVED

4300

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>75x</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenside</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Crichton</u> Last <u>Wetmore</u>		4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-6-84</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>21</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Crichton</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Crichton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>husband</u> Address <u>Albert Wetmore</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 26, 1956</u> , to <u>April 27, 1956</u> that I last saw the deceased alive on <u>April 27, 1956</u> , and that death occurred at <u>5:35 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10644 Conn Ave Kensington, Md.</u> DATE SIGNED <u>4-28-56</u>			
ACTUAL SIGNATURE <u>George Sharpe</u>		PHYSICIAN'S NAME (Type) <u>George Sharpe</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Bur-transit</u>	<u>4/28/56</u>	<u>Whitemarsh Mem. Pk.</u>	<u>Glenside Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</u>		24a. REC'D BY REGISTRAR <u>4-29-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

MEDICAL CERTIFICATION

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JAN 11 1941

LIBRARY  
JAN 11 1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 2/6

04290

4371

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Rockville</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 hrs. 25 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>409 Blandford St.</u>	
3. NAME OF DECEASED (Type or print) <u>James Wesley Baby Boy Whitacre</u>		4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs <u>2</u> Months <u>8</u> Days <u>25</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Whitacre</u>		14. MOTHER'S MAIDEN NAME <u>Wanda Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Father John Whitacre</u>		Address <u>409 Blandford St. Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (approximately 5 months)</u> DUE TO <u>176x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>10:30 AM 4/7</u> , 19 <u>56</u> , to <u>NATM 4/7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/7</u> , 19 <u>56</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Audrey J. McDonald</u>		M.D. <u>809 VIER'S MILL RD ROCKVILLE, MD. 4/10/56</u>	
PHYSICIAN'S NAME (Type) _____		DATE SIGNED _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - Trans</u>	22b. DATE THEREOF <u>4-9-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gravel Springs Cemetery</u>	22d. LOCATION (City, town, or county) <u>Star Tannery, Frederick Co., Va</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Humphrey</u>		ADDRESS <u>7557 Wisconsin Ave.</u>	
24a. REC'D BY REGISTRAR <u>DATE 4/10/56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4302

## CERTIFICATE OF DEATH

04291

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>105 E. Lenox Street</b>				d. STREET ADDRESS <b>105 E. Lenox Street</b>			
3. NAME OF DECEASED (Type or print) <b>GERTRUDE</b> First <b>R.</b> Middle <b>WILLIAMS</b> Last				4. DATE OF DEATH <b>April 10,</b> Month <b>1956</b> Day Year			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 29, 1889</b>		9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>11</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wm. Henry Robeson</b>				14. MOTHER'S MAIDEN NAME <b>Indie Ferguson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>L.L. Williams, Jr. - Item # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized metastatic carcinoma</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of left breast (anaplastic)</b> DUE TO (c) <b>8 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>55</b> to <b>4-10</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>about 3-5</b> , 19 <b>56</b> , and that death occurred at <b>430 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles A. Jarvis, Sr. Surgeon, U.S.P.H.S.</b>				ADDRESS (Street, city or town, state) <b>U.S.P.H.S. Outpatient Clinic</b> DATE SIGNED <b>4-10-56</b>			
PHYSICIAN'S NAME (Type) <b>Charles A. Jarvis</b>				<b>4th &amp; D. St. S. W. Wash, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-12-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 4/10/56</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

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4175  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1002 Lewis Ave.</b>		d. STREET ADDRESS <b>1002 Lewis Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>EMMA ELIZABETH</b> First Middle Last		4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 16, 1887</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>3</b> Days <b>12</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Franklin Fuller</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Jessie W. Broadhurst</b>		Address <b>5919 Lone Oak Dr. Bethesda, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Regurgitation of mucus due to paroxysm of swelling mucus - Parkinsonism</b> (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>12 hrs</b> <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-11-1954</b> to <b>4-29-1956</b> , that I last saw the deceased alive on <b>4/28/1956</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stephen N. Jones</b> M.D.		ADDRESS (Street, city or town, state) <b>Rockville, Md.</b> DATE SIGNED <b>4/29/56</b>	
PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b>		<b>Rockville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-1-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Montgomery County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR <b>5/2/56</b>		24b. REGISTRAR'S SIGNATURE <b>Laurel H. Kraytor</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 10 1956

RECEIVED

2/12/56 - James Earl Ray

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 could be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

1  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**4303 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04293

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>				d. STREET ADDRESS <u>316 N. Washington St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward</u> <u>Charles</u>				4. DATE OF DEATH Month Day Year <u>Apr</u> <u>15</u> <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 14 1871</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. Tech</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Word Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Russell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mr &amp; Mrs Word 1945 Martin St. Rockville md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Haiti</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4/21/56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

S. A. OYSTER

W. F. OYSTER

DEALER

4170

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Attakoma Park</u>		c. LENGTH OF STAY IN 1b <u>14 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank Frederick Wood</u>		d. STREET ADDRESS <u>606 Greenbrier Drive</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>9-11-05</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank E. Wood</u>		14. MOTHER'S MAIDEN NAME <u>Marion Dohman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>148X ASPHYXIATION</u> DUE TO (b) <u>CARCINOMA OF THE THROAT</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>7 mos. +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>MALNUTRITION</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-9</u> to <u>APR. 14, 1956</u> , that I last saw the deceased alive on <u>APR. 13, 1956</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. Marshall Cuvillier, Jr.</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>L. Marshall Cuvillier, Jr.</u>		<u>1407-1409 Woodside Pkwy. Silver Spring, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/16/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner &amp; Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>4-16-56</u> 24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dold</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

1. Name of Deceased		2. Sex		3. Race	
4. Date of Birth		5. Date of Death		6. Place of Birth	
7. Usual Residence		8. Cause of Death		9. Manner of Death	
10. Physician		11. Hospital		12. Burial Place	
13. Signature of Registrar		14. Signature of Physician		15. Signature of Coroner	

BUREAU V. S.

APR 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4304

## CERTIFICATE OF DEATH

04295  
214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>6 YRS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1303 MONTGOMERY STREET</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>1303 MONTGOMERY STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EIMIRA</b> Middle <b>E.</b> Last <b>Zeidler</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>14</b> Year <b>19 56</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/25/84</b>
9. AGE (In years last birthday) <b>72</b>		10. IF UNDER 1 YEAR: Months <b>12</b> Days <b>14</b> Hours <b>19</b> Min. <b>56</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11c. BIRTHPLACE (State or foreign country) <b>PHILADELPHIA, PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN BEAR</b>		14. MOTHER'S MAIDEN NAME <b>EMMA BEAR</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>YES</b>	
17. INFORMANT <b>Mrs. Edna M. Weidler, 1303 Montgomery St. Silver Spring, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinomatosis</b> DUE TO <b>153X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Colon</b> DUE TO (c) <b>153X</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/9</b> , 19 <b>53</b> to <b>4/14</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Apr. 9</b> , 19 <b>56</b> , and that death occurred at <b>1 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dean H. Harding</b>		ADDRESS (Street, city or town, state) <b>113 CARROLL ST NW WASH., DC</b>	
PHYSICIAN'S NAME (Type) <b>DEAN H. HARDING</b>		DATE SIGNED <b>4/14/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/20/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR LAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>LANCASTER, PA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b> ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>4/17/56</b>	
24b. REGISTRAR'S SIGNATURE <b>Stance Teller</b>			

Dr Brochant, Montgomery Co.,  
Cormer, notified and  
will approve.

Leah Harding

RECEIVED  
APR 19 1936

BUREAU V. S.

CELEBRATE THE GREAT

WARRANTING EVIDENCE OF THE GREAT